

MAT Diabetes Part 1

Version 10/30/2016

Handouts

*Bring these handouts to your Part 2 class!*





## Glossary

<u>Term</u>	<u>Definition</u>
autoimmune	An autoimmune response is a failure of an organism to recognize its own constituent parts, resulting in an immune response against its own tissues and cells
basal	Baseline or minimum level required throughout the day
blood glucose	The main sugar that the body makes from food in the diet. Glucose is carried through the bloodstream to provide energy to all the cells in the body.
bloodborne pathogens	Infectious microorganisms that cause disease in humans, such as HIV, hepatitis B and C.
bolus insulin	Rapid acting insulin such as Humalog, Novolog, Apidra
cannula	a flexible tube that attaches a glucose pump to the body. If it becomes clogged or is pulled out, the child can develop hyperglycemia.
carbohydrate	One of three major nutrients, along with fats and protein, used by the body. Includes simple sugars, starches, and fiber. When eaten, all carbohydrates are broken down into the sugar glucose.
correction factor	The amount of insulin needed to correct a blood glucose level above the student's target range. This will vary from child to child. For example, if the child's pre-meal blood glucose is 300 and their target range is 150, and the correction factor is 1 unit of insulin for every 50 mg/dl over target, the dosage is $300-150=150$ , divided by 50, or 3 additional units. Note: correction doses should not be given if the previous two hours the child has eaten, has already been given a correction dose, or treatment for low blood glucose.
diabetes	A disease in which the body does not make or properly use insulin. It is a chronic (long term) disease with serious health consequences. Treatment mimimizes the damage caused by the disease but does not cure the disease.
diabetes type 2	The body is producing insulin, but not enough, or the body is not using its insulin properly. Usually begins in adulthood, but is increasingly seen in children. Being overweight and lack of exercise contributes to the development of the disease.
diabetes type1	The insulin-producing cells in the body are destroyed by the body's immune system. Most commonly develops in children. People with type 1 diabetes MUST take insulin.
fast acting carbohydrate	Food that is digested quickly, and is rapidly converted to glucose in the blood. Includes sugar, corn syrup, sugar-containing fruit juice, and skim milk.
fast acting sugars	See fast acting carbohydrate



## Glossary

gestational diabetes	Diabetes that occurs during pregnancy and generally ends when the pregnancy is over.
glucometers	a device that takes measures blood glucose levels using a very small sample of blood
glucagon	A hormone given by injection that raises the level of glucose in the blood.
glycemic	Related to glucose in the blood
hyperglycemia	Too much sugar in the blood, although the body's cells are starving because the glucose cannot get into the cells.
hypoglycemia	Blood glucose levels below 70 mg/dl. This is the greatest immediate danger to children with diabetes. It impairs mental and physical functions. It can be caused by too much insulin, too little food, or extra physical activity. When in doubt always treat.
insulin	A natural hormone made in the pancreas that controls the level of blood glucose in the blood.
insulin pen	An insulin injection device with a dial to select the desired dose.
insulin pump	A programmable insulin delivery device. About the size of a pager, weighing about three ounces, worn on a belt or in a pocket. Connected to a plastic tube that ends with a needle inserted just under the skin in the abdomen. It delivers a constant "basal" amount of insulin throughout the day and a "bolus" dose at meals, and at times when blood sugar levels are too high.
insulin syringe	A small sized syringe marked in units and used for insulin injections
insulin to carbohydrate ratio	The amount of carbohydrate that one unit of insulin will cover or match. For example, if the ratio is 1:10, you will need 1 unit of rapid or short-acting insulin to cover every 10 grams of carbohydrate. The ratio will vary from child to child.
intramuscular (IM)	An intramuscular (IM) injection is given by needle into the muscle. This is typically accomplished by injecting directly downward into skin that has not been pinched up, so that the needle will reach the muscle.
jet injector	Devices that send a fine spray of insulin through the skin by a high pressure air mechanism instead of needles.
ketoacidosis (DKA)	When ketone levels in the blood reach an emergency state that can lead to coma or death. Symptoms include fruity odor to breath, nausea, vomiting, drowsiness.
ketones	Acids that build up in the body when fat is used for energy and cause the child to feel ill



## Glossary

lancet	A sharp-pointed instrument used to make small incisions.
sharp	Any medical device with a sharp or pointed end capable of breaking the skin. Includes injection needles and blood glucose testing lancets.
subcutaneous (SC)	Under the skin. For example, a subcutaneous (SC) injection is an injection in which a needle is inserted just under the skin, but not into the muscle. This is typically accomplished by pinching the injection site up and then injecting.





## Blood Glucose Target Recommendations by Age

Diabetes must be managed 24 hours a day, 7 days a week. Managing diabetes is a constant quest to achieve the right balance between food intake, physical activity, and insulin amounts in order to keep blood sugar levels in the target range. Factors such as exercise, illness, and stress, make it difficult to always maintain that perfect balance. When the balance is tipped, the child experiences symptoms of blood sugars that are too high or too low. Blood sugars that are too high or too low are serious and require proper recognition and action by trained adults to help keep children healthy.

It is important to remember that the medical management of diabetes should be individualized to the needs of the person. Healthcare providers may vary target ranges for blood sugars taking into account the benefits and the risks, the frequency of low blood sugars, and the individual's ability to recognize a low.

The American Diabetes Association recommends the following target blood glucose ranges before meals:

<u>Values by Age</u>	<u>Blood Glucose (mg/dL)</u>
Toddlers and Preschoolers (0-6 years)	100-180
School Age (6-12 years)	90-180
Adolescents and Young Adults	90-130

Taking care of diabetes is important. If not treated, diabetes can lead to serious health problems. The disease can affect the blood vessels, eyes, kidneys, nerves, gums, and teeth, and it is the leading cause of adult blindness, non-traumatic lower limb amputations, and kidney failure. People with diabetes also have a higher risk of heart disease and stroke. Research shows that these problems can be greatly reduced or delayed by keeping blood glucose levels near normal.





## Diabetes: Types 1 & 2

Description, Symptoms and Risk Factors

### Type 1 Diabetes

Type 1 diabetes mellitus (T1DM) is a complex metabolic disease. In people with T1DM, the immune system attacks the beta cells (the insulin-producing cells of the pancreas) and destroys them. Because the pancreas can no longer produce insulin, people with T1DM need to take insulin and/or oral medications on a daily basis to live. T1DM can occur at any age, but it begins most often in children and young adults. Currently, there is no cure for T1DM, but research into prevention and treatment is ongoing.

<u>Symptoms</u>	<u>Risk Factors</u>
<ul style="list-style-type: none"><li>• increased thirst</li><li>• increased urination</li><li>• constant hunger</li><li>• weight loss</li><li>• blurred vision</li><li>• fatigue</li></ul>	<ul style="list-style-type: none"><li>• genetics</li><li>• environment</li></ul>

### Type 2 Diabetes

The first step in the development of type 2 diabetes mellitus (T2DM) is often a problem with the body's response to insulin, or insulin resistance. For reasons scientists do not completely understand, the body cannot use its insulin very well. This means that the body needs increasing amounts of insulin to control blood glucose. The pancreas tries to make more insulin, but after several years, insulin production may drop off. Children with T2DM may need to take oral medication, insulin, or both.

T2DM is a disease found mainly in overweight adults ages 40 or older. With the epidemic of childhood obesity and low levels of physical activity in today's youth, more children and adolescents are being diagnosed with T2DM. A healthy diet, adequate exercise, and weight management may decrease the risk of getting T2DM.

<u>Symptoms</u>	<u>Risk Factors</u>
<ul style="list-style-type: none"><li>• fatigue</li><li>• increased thirst</li><li>• increased urination</li><li>• nausea</li><li>• rapid weight loss</li><li>• blurred vision</li><li>• frequent infections</li><li>• slow healing of wounds or sores</li></ul>	<ul style="list-style-type: none"><li>• being overweight (greater than 85<sup>th</sup> percentile for height/weight)</li><li>• having a family member who has type 2 diabetes or a mother who had gestational diabetes</li><li>• African American, Hispanic/Latino, Native American, Asian, or Pacific Islander Ethnicity</li></ul>





## Authorization for MAT Diabetes Certified Staff to Administer Insulin and/or Glucagon

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

### Child Day Program Information

Child Day Program Name: \_\_\_\_\_

Child Day Program Address: \_\_\_\_\_

Name of MAT Diabetes Certified Staff Authorized to Administer Insulin and/or Glucagon to above child: \_\_\_\_\_

\*A new form must be completed should any of the above relevant staff change.

Child Day Program Director Name: \_\_\_\_\_

Child Day Program Director Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Physician and Parent/Guardian Authorization

Treating Physician's Name: \_\_\_\_\_

Treating Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I understand that the above-named MAT Diabetes certified staff person(s) is (are) not a health care professional licensed to administer medications (not a registered nurse, licensed practical nurse, doctor of medicine or osteopathic medicine, or pharmacist)

I authorize the above-named MAT Diabetes certified staff person(s) to administer insulin and/or Glucagon to the above-named child.

Child's Parent/Guardian Name: \_\_\_\_\_

Child's Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_





This plan should be completed by the child’s personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant program staff and copies should be kept in a place that can be accessed easily by the program nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: \_\_\_\_\_ This plan is valid for the current year: \_\_\_\_\_

Child’s Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Diabetes Diagnosis: \_\_\_\_\_  type 1  type 2  Other

Program: \_\_\_\_\_ Program Phone Number: \_\_\_\_\_

Age Group: \_\_\_\_\_ Classroom Teacher: \_\_\_\_\_

MAT Diabetes certified staff or other qualified health care professional:

\_\_\_\_\_

Phone: \_\_\_\_\_

### **CONTACT INFORMATION**

Mother/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Father/ Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Child’s Physician/Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Emergency Number: \_\_\_\_\_

Other Emergency Contacts: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_



**CHECKING BLOOD GLUCOSE**

Target range of blood glucose: \_\_\_\_\_  70-130 mg/dL  70-180 mg/dL

Other: \_\_\_\_\_

Check blood glucose level:  Before lunch  \_\_\_ Hours after lunch

2 hours after a correction dose  Mid-morning  Before physical activity (PE)  After PE

Before dismissal  Other: \_\_\_\_\_

As needed for signs/ symptoms of low or high blood glucose

As needed for signs/ symptoms of illness

Preferred site of testing:  Fingertip  Forearm  Thigh  Other:

Brand/Model of blood glucose meter: \_\_\_\_\_

*Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.*

**Child’s self-care blood glucose checking skills:**

Independently checks own blood glucose

May check blood glucose with supervision

Requires child day program administrator/director or MAT Diabetes certified staff to check blood glucose

**Continuous Glucose Monitor (CGM):**  Yes  No

Brand/Model: \_\_\_\_\_ Alarms set for:  (low) and  (high)

*Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If child has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.*

**HYPOGLYCEMIA TREATMENT**

Child’s usual symptoms of hypoglycemia (list below):

\_\_\_\_\_  
\_\_\_\_\_

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than \_\_\_ mg/dL, give a quick-acting glucose product equal to \_\_\_ grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than \_\_\_ mg/dL.

Additional treatment: \_\_\_\_\_



**HYPOGLYCEMIA TREATMENT (Continued)**

Follow physical activity and sports orders (see page 7).

- If the child is unable to eat or drink, is unconscious or unresponsive, or is having seizures activity or convulsions (jerking movements), give:
- Glucagon:  1 mg    ½ mg   Route:  SC(subcutaneous)    IM(intramuscular)
- Site for glucagon injection:  arm    thigh    Other: \_\_\_\_\_
- Call 911 (Emergency Medical Services) and the child’s parents/guardian.
- Contact child’s health care provider.

**HYPERGLYCEMIA TREATMENT**

Child’s usual symptoms of hyperglycemia (list below):

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Check  Urine    Blood for ketones every \_\_\_ hours when blood glucose levels are above \_\_\_ mg/dL.

For blood glucose greater than \_\_\_ mg/dL AND at least \_\_\_ hours since last insulin dose, give correction dose of insulin (see orders below).

For insulin pump users: see additional information for a child with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices): \_\_\_ ounces per hour.

Additional treatment for ketones: \_\_\_\_\_

Follow physical activity and sports orders (see page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the child has symptoms of hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the child’s parents/guardian.
- Contact child’s health care provider.



**Insulin therapy**

Insulin delivery device:  syringe  insulin pen  insulin pump

Type of insulin therapy at the child day program:

- Adjustable Insulin Therapy
- Fixed Insulin Therapy
- No insulin

**Adjustable Insulin Therapy**

- **Carbohydrate Coverage/ Correction Dose:**

Name of insulin: \_\_\_\_\_

**Meal Matrix** (see Correction Matrix for Dosage Adjustments)

Meal	Grams Carbs	Insulin Dose in Units	Meal	Grams Carbs	Insulin Dose in Units

- **Carbohydrate Coverage:**

Insulin-to-Carbohydrate Ratio: \_\_\_\_\_

Lunch: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

Snack: 1 unit of insulin per \_\_\_\_\_ grams of carbohydrate

**Carbohydrate Dose Calculation Example**

$$\frac{\text{___ Grams of carbohydrate in meal}}{\text{___ Insulin-to-carbohydrate ratio}} = \text{___ units of insulin}$$

**Correction dose matrix** (use instead of calculation below to determine insulin correction dose):

Blood Glucose	Correction Dose in Units
___ to ___ mg/dL	



• **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor= \_\_\_\_\_

Target blood glucose= \_\_\_\_\_ mg/dL

**Correction Dose Calculation Example**

\_\_\_\_ *Actual Blood Glucose* – \_\_\_\_ *Target Blood Glucose*

\_\_\_\_ *Blood Glucose Correction Factor/Insulin Sensitivity Factor* = \_\_\_\_\_ units of insulin

**When to give insulin:**

Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_ mg/dL and \_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than \_\_\_\_ mg/dL and \_\_\_\_ hours since last insulin dose.
- Correction dose only:  
For blood glucose greater than \_\_\_\_ mg/dL AND at least \_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

**Fixed Insulin Therapy**

Name of insulin: \_\_\_\_\_

- \_\_\_\_ Units of insulin given pre-lunch daily
- \_\_\_\_ Units of insulin given pre-snack daily
- Other: \_\_\_\_\_



**Parent Authorization to Adjust Insulin Dose:**

- Yes     No    Parents/guardian authorization should be obtained before administering a correction dose.
- Yes     No    Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- \_\_\_\_ units of insulin
- Yes     No    Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: \_\_\_\_ units per prescribed grams of carbohydrate, +/- \_\_\_\_ grams of carbohydrate.
- Yes     No    Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_ units of insulin.

**Child's self-care insulin administration skills:**

- Yes     No    Independently calculates and give own injections
- Yes     No    May calculate/give own injections with supervision
- Yes     No    Requires MAT/Diabetes certified staff or other qualified health care professional to calculate/give injections.

**ADDITIONAL INFORMATION FOR CHILD WITH INSULIN PUMP**

Brand/Model of pump \_\_\_\_\_ Type of insulin in pump: \_\_\_\_\_

Basal rates during program: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

- For blood glucose greater than \_\_\_\_ mg/dL that has not decreased within \_\_\_\_ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.
- For infusion site failure: Insert new fusion set and/ or replace reservoir.
- For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

**Physical Activity**

- May disconnect from pump for sports activities     Yes     No
- Set a temporary basal rate     Yes     No    % temporary basal for \_\_\_\_\_ hours
- Suspend pump use     Yes     No



**Independent?**

**Child's self-care pump skills:**

- Counts carbohydrates  Yes  No
- Bolus correct amount for carbohydrates consumed  Yes  No
- Calculate and administer correction bolus  Yes  No
- Calculate and set basal profiles  Yes  No
- Calculate and set temporary basal rate  Yes  No
- Change batteries  Yes  No
- Disconnect pump  Yes  No
- Reconnect pump to infusion set  Yes  No
- Prepare reservoir and tubing  Yes  No
- Insert infusion set  Yes  No
- Troubleshoot alarms and malfunctions  Yes  No

**OTHER DIABETES MEDICATIONS**

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

**MEAL PLAN**

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	_____	_____ to _____
Mid-morning snack	_____	_____ to _____
Lunch	_____	_____ to _____
Mid-afternoon snack	_____	_____ to _____

Other times to give snacks and content/amount: \_\_\_\_\_

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

- Special event/party food permitted:  Parents/guardian discretion  
 Child discretion



**Child's self-care nutrition skills:**

- Yes  No Independently counts carbohydrates
- Yes  No May count carbohydrates with supervision
- Yes  No Requires MAT Diabetes certified staff or other qualified health care professional to count carbohydrates

**PHYSICAL ACTIVITY AND SPORTS**

A quick-acting source of glucose such as  glucose tabs and/or  sugar-containing juice must be available at the site of physical education activities and sports.

Child should eat  15 grams  30 grams of carbohydrates  other  before  every 30 minutes during  after vigorous physical activity  other: \_\_\_\_\_

If most recent blood glucose is less than \_\_\_\_\_ mg/dL, child can participate in physical activity when blood glucose is correct and above \_\_\_\_\_ mg/dL.

Avoid physical activity when blood glucose is greater than \_\_\_\_\_ mg/dL or if urine/blood ketones are moderate to large.

(Additional information for child on insulin pump is in the insulin section on page 6.)

**DISASTER PLAN**

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

- Continue to follow orders contained in this DMMP.
- Additional insulin orders as follows: \_\_\_\_\_
- Other: \_\_\_\_\_



**SIGNATURES**

This Diabetes Medical Management Plan has been approved by:

Child’s Physician/Health Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

I, (parent/guardian:) \_\_\_\_\_ give permission to the MAT Diabetes certified staff or other qualified health care professional of (program:) \_\_\_\_\_ to perform and carry out the diabetes care tasks as outlined in (child:) \_\_\_\_\_’s

Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all program staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I also give permission to the MAT Diabetes certified staff or other qualified health care professional to contact my child’s physician/health care provider.

Acknowledged and received by:

\_\_\_\_\_  
Child’s Parent/Guardian Date

\_\_\_\_\_  
Child’s Parent/Guardian Date

\_\_\_\_\_  
MAT Diabetes Certified Staff/Other Qualified Health Care Personnel Date



### III. Virginia School Diabetes Medical Management Forms

Student \_\_\_\_\_ School \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

Dear Parent/Guardian:

1. **Part 1-** Medical history and contact information. To be completed by parent/guardian.  
 Includes: Parent authorization for trained school designees. To be completed by parent/guardian.
2. **Part 2\*-** Have your child's physician complete unless the physician's office prefers to use his/her own *Diabetes Medical Management Plan*. Please note that physician authorization for treatment by trained school designees must be included in the Diabetes Medical Management Plan or a separate form must be provided.
3. **Part 3\*-** Have the physician/diabetes educator/caregiver complete if your child wears an insulin pump.
4. **Part 4-** If your child is going to carry and self administer insulin and perform blood sugar checks in the classroom; an "*Authorization to Carry and Self-Administer Medication Form*" must be completed by the physician, school nurse and the parent.

\*Other Diabetic Medical Management Plans may be used for **Parts 2 & 3** as long as all components are represented.

Return completed forms to the school nurse as quickly as possible. Thank you for your cooperation.

School nurse \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Please note: during the school year, in order to change your child's diabetes care at school, an updated physician's order must be submitted to the school nurse.

#### Part 1: Parent/Guardian to complete:

##### Contact Information:

Parent/Guardian #1: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Other emergency contact: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Physician managing diabetes: \_\_\_\_\_

Address: \_\_\_\_\_

Main Office # \_\_\_\_\_ Fax # \_\_\_\_\_ Emergency Phone # \_\_\_\_\_

Nurse/Diabetes Educator \_\_\_\_\_ Work # \_\_\_\_\_

<b>Diabetes Questions</b>	<b>Parent/Guardian Response (check appropriate boxes and complete blanks)</b>
Diagnosis information	At what age? _____ Type of diabetes? _____
How often is child seen by this physician? <i>Include date last seen.</i>	
Nutritional needs	♦ Snack <input type="checkbox"/> ____AM <input type="checkbox"/> ____PM <input type="checkbox"/> ____Prior to Exercise/Activity <input type="checkbox"/> Only in case of low blood glucose <input type="checkbox"/> Student may determine if CHO counting

	<input type="checkbox"/> In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) <input type="checkbox"/> student able to determine whether to eat the treat <input type="checkbox"/> replace with parent supplied treat <input type="checkbox"/> may NOT eat the treat <input type="checkbox"/> other _____
Child's most common signs of low blood glucose	<input type="checkbox"/> trembling <input type="checkbox"/> tingling <input type="checkbox"/> loss of coordination <input type="checkbox"/> dizziness <input type="checkbox"/> moist skin/sweating <input type="checkbox"/> slurred speech <input type="checkbox"/> heart pounding <input type="checkbox"/> hunger <input type="checkbox"/> confusion <input type="checkbox"/> weakness <input type="checkbox"/> fatigue <input type="checkbox"/> seizure <input type="checkbox"/> pale skin <input type="checkbox"/> headache <input type="checkbox"/> unconsciousness <input type="checkbox"/> change in mood or behavior <input type="checkbox"/> other _____
How often does child experience low blood glucose and how severe?	<b>Mild</b> <input type="checkbox"/> once a day <input type="checkbox"/> once a week <input type="checkbox"/> once a month Indicate date(s) of last mild episode(s) _____  <b>Severe</b> (i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s) _____
Episode(s) of ketoacidosis	Include date(s) of recent episode(s) _____
Field trips	Parent/guardian will accompany child during field trips? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Yes, if available
Serious illness, injuries or hospitalizations this past year	Date(s) and describe _____
List any other medications currently being taken	_____
Allergies (include foods, medications, etc):	_____
Other concerns and comments	_____

I give permission to the school nurse and designated school personnel\*, who have been trained and are under the supervision of the school nurse to perform and carry out the diabetes care tasks as outlined in my child's *Diabetes Medical Management Plan* as ordered by the physician. I give permission to the designated school personnel, who have been trained to perform the following diabetes care tasks for my child. (Code of Virginia§ 22.1-274).

Insulin Administration     YES       NO      Glucagon Administration     YES       NO

I understand that I am to provide all supplies to the school necessary for the treatment of my child's diabetes. I also consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician and members of the diabetes management team regarding my child's diabetes should the need arise.

Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

School Nurse's Name \_\_\_\_\_ Date \_\_\_\_\_

School Nurse's Signature \_\_\_\_\_

\*Note: If at any time you would like to have the names of the designated school personnel that have been trained, please contact the school nurse. Names and training records are kept in the school clinic.



**DIABETES MEDICAL MANAGEMENT PLAN  
CONVENTIONAL THERAPY or TYPE 2**

**DIABETES SCHOOL CARE PLAN  
CONVENTIONAL THERAPY OR TYPE 2 DIABETES**

**Student:**  
**Effective date:**

INSULIN																	
Insulin to be given during school hours: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student can administer insulin if supervised																	
<b>Insulin Types:</b> <input type="checkbox"/> Rapid-acting Insulin Type: _____ <sup>®</sup> <input type="checkbox"/> Short-acting Insulin Type: <b>Regular</b>  <input type="checkbox"/> Intermediate-acting Insulin Type: <b>NPH</b> <input type="checkbox"/> may mix with rapid or short-acting insulin  <input type="checkbox"/> Long-acting Insulin Type: _____ <sup>®</sup> _____ units at _____ am or pm <input type="checkbox"/> may mix with rapid-acting insulin  <i>(all doses to be administered subcutaneously)</i>	<input type="checkbox"/> <b>Meal Plan:</b> <input type="checkbox"/> according to the following distribution: Breakfast: _____ grams AM Snack: _____ grams Lunch: _____ grams PM Snack: _____ grams  <input type="checkbox"/> <b>Insulin:CHO Ratio:</b> 1 unit for every _____ grams of CHO <input type="checkbox"/> decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise is anticipated.																
<input type="checkbox"/> Pre-breakfast dose:    Regular _____ units    Humalog® or Novolog® or Apidra® _____ units    NPH _____ units <input type="checkbox"/> Pre-lunch dose:        Regular _____ units    Humalog® or Novolog® or Apidra® _____ units    NPH _____ units <input type="checkbox"/> Pre-dinner dose:        Regular _____ units    Humalog® or Novolog® or Apidra® _____ units    NPH _____ units																	
<input type="checkbox"/> <b>Sliding scale to be administered at _____ (times)</b>  <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 40%;">If blood glucose</td> <td style="width: 60%;">Units of rapid-acting Insulin subq</td> </tr> <tr> <td>_____ give _____</td> <td>_____</td> </tr> </table>	If blood glucose	Units of rapid-acting Insulin subq	_____ give _____	_____	<input type="checkbox"/> <b>Insulin Sensitivity (Correction Factor) to be administered at _____ (times)</b> <ul style="list-style-type: none"> <li>the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin</li> <li>usually expressed as "1 unit for every _____ mg/dL blood glucose is &gt; target"</li> <li>If uneven, then round to the nearest <b>half or whole unit</b> (May use clinical discretion; if physical activity follows meal, then may round down)</li> </ul> Sensitivity: _____  Target: _____												
If blood glucose	Units of rapid-acting Insulin subq																
_____ give _____	_____																
_____ give _____	_____																
_____ give _____	_____																
_____ give _____	_____																
_____ give _____	_____																
_____ give _____	_____																
<input type="checkbox"/> Other Instructions:																	

**Snacks**

- Children using NPH insulin usually require snacks without additional insulin coverage (please, adhere to CHO amounts ordered above).
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.  

Before Exercise                       After Exercise
- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

**Exercise and Sports**

- In general, there are no restrictions on activity unless specified.
- A student should not exercise if his/her blood glucose is <100 mg/dL or > 300 mg/dL and ketones are positive.
- A source of fast-acting glucose & glucagon (if ordered) should be available in case of hypoglycemia.

Specific duration of order: <b>2013-2014 SCHOOL YEAR</b>	Physician/Provider Signature: _____    Provider Printed Name: _____	Office Phone: _____ Office Fax: _____
---	---	--

**DIABETES MEDICAL MANAGEMENT PLAN  
CONVENTIONAL THERAPY or TYPE 2**

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**DIABETES SCHOOL CARE PLAN**

**Student:**  
**Effective date:**

**Hypoglycemia (Low Blood Glucose)**

Hypoglycemia is defined as a blood glucose  $\leq$  \_\_\_\_\_ mg/dL

Signs of hypoglycemia:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Fighting	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

- If hypoglycemia is suspected, check the blood glucose level.

<b>Hypoglycemia Management (Low Blood Glucose)</b>	<b>Severe Hypoglycemia: If student unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing, administer glucagon.</b>
	<ul style="list-style-type: none"> <li>• Place student in the "recovery position."</li> <li>• If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.</li> </ul>
	<b>Mild or Moderate Hypoglycemia: If conscious &amp; able to swallow, immediately give 15 gram fast-acting glucose:</b>
	<ul style="list-style-type: none"> <li>• 3-4 glucose tablets or</li> <li>• 6 Life Saver® Candies or</li> <li>• 4 ounces of regular soda/juice or</li> <li>• 1 small tube Glucose/Cake gel</li> </ul>
	<b>Repeat BG check in 15 minutes</b>
	<ul style="list-style-type: none"> <li>• If BG still low, then re-treat with 15 gram CHO</li> <li>• If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders</li> <li>• If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (3-4 peanut butter or cheese crackers or ½ sandwich)</li> </ul>
	If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call

**Hyperglycemia (High Blood Glucose)**

Signs of hyperglycemia:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Dry Skin	Dizziness	Stomachache

- If hyperglycemia is suspected, check the blood glucose level.

<b>Hyperglycemia Management (High Blood Glucose)</b>	<b>If BG &gt; 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones</b>
	<ul style="list-style-type: none"> <li>• If urine ketones are trace or negative (blood ketones 0 - 1mmol/L), give 8-16 ounces of sugar-free fluid (water), return to classroom.</li> <li>• If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG</li> <li>• Recheck BG and ketones 2 hours after administering insulin</li> </ul>
	<ul style="list-style-type: none"> <li>• If urine ketones are moderate/large (blood ketones &gt; 1mmol/L), give 8-16 ounces of sugar-free fluid (water) and call for instructions concerning insulin administration.</li> <li>• Contact the Parent/Legal Guardian.</li> <li>• Recheck BG and ketones 2 hours after administering insulin</li> </ul>

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations. I also give permission for the school to contact the health care provider regarding these orders and administration of these medications.

School plan ordered by:	Physician/Provider Signature:	Provider Printed Name:	Date:
Acknowledged and received by:	Parent/Legal Guardian:		Date:
Acknowledged and received by:	School Representative:		Date:



# Individualized Health Care Plan (IHP)

Handout C.2

Child: \_\_\_\_\_

Grade: \_\_\_\_\_

Dates: \_\_\_\_\_

School Year: \_\_\_\_\_

IHP Completed by and Date: \_\_\_\_\_

IHP Review Dates: \_\_\_\_\_

Nursing Assessment Review: \_\_\_\_\_

Nursing Assessment Completed by and date: \_\_\_\_\_

Nursing Diagnosis	Same Interventions and Activities	Date Implemented	Sample Outcome Indicator	Date Evaluated
<p><b>Managing Potential Diabetes Emergencies</b></p> <p>(risk for unstable blood glucose)</p>	<p>Establish and document student's routine for maintaining blood glucose within goal range including while at child day program or school:</p> <p><b>Blood Glucose Monitoring</b></p> <ul style="list-style-type: none"> <li>• Where to check blood glucose:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Classroom</li> <li><input type="checkbox"/> Health room</li> <li><input type="checkbox"/> Other</li> </ul> </li> <li>• When to check blood glucose:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Before breakfast</li> <li><input type="checkbox"/> Mid-morning lunch</li> <li><input type="checkbox"/> After lunch</li> <li><input type="checkbox"/> Before snack</li> <li><input type="checkbox"/> Before PE</li> <li><input type="checkbox"/> After PE</li> <li><input type="checkbox"/> 2 hours after correction dose</li> <li><input type="checkbox"/> Before dismissal</li> <li><input type="checkbox"/> As needed</li> <li><input type="checkbox"/> Other: _____</li> </ul> </li> <li>• Child Self-Care Skills:                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Independent</li> <li><input type="checkbox"/> Supervision</li> <li><input type="checkbox"/> Full assistance</li> </ul> </li> <li>• Brand/model of BG meter: _____</li> <li>• Brand/Model of CGM _____</li> </ul>		<div style="border: 1px solid black; padding: 10px; text-align: center;"> <p><b>Blood glucose remains in goal range</b></p> <p>Percentage of Time</p> </div>	

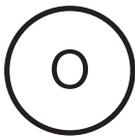
## Individualized Health Care Plan (IHP) (Continued)

Nursing Diagnosis	Sample Interventions and Activities	Date Implemented	Sample Outcome Indicator	Date Evaluated
<p><b>Supporting the Independent Child</b> (effective therapeutic regimen management)</p>	<p><b>Hypoglycemia Management</b> <b>CHILD WILL:</b></p> <ul style="list-style-type: none"> <li>• Check blood glucose when hypoglycemia suspected</li> <li>• Treat hypoglycemia (follow Diabetes Emergency Care Plan) take action following a hypoglycemia episode:</li> </ul> <hr/> <ul style="list-style-type: none"> <li>• Keep quick-acting glucose product to treat on the spot Type: _____ Location: _____</li> <li>• Routinely monitor hypoglycemia trends r/t class schedule (e.g., time of PE, schedule lunch, recess) and insulin dosing</li> <li>• Report and consult with parents/guardian, school nurse, HCP, and/or child day program or school personnel as appropriate</li> </ul>		<div style="border: 1px solid black; padding: 5px;"> <p><b>Monitors Blood Glucose</b> (records, reports, and correctly responds to results)</p> </div>	
<p><b>Supporting Positive Coping Skills</b> (readiness for enhanced coping)</p>	<p><b>Environment Management</b></p> <ul style="list-style-type: none"> <li>• Ensure confidentiality</li> <li>• Discuss with parents/guardian and child preference about who should know child's coping status at child day program or school</li> <li>• Collaborate with parents/guardian and child day program or school personnel to meet child's coping needs</li> <li>• Collaborate with child day program or school personnel to create an accepting and understanding environment</li> </ul>		<div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;"><b>Readiness to Learn</b></p> <p style="text-align: center;">Severely <span style="float: right;">not</span></p> </div>	

### CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

	Today's Date			
Child's Full Name	Date of Birth			
Parent's/Guardian's Name	Telephone No. (    )			
Primary Health Care Provider	Telephone No. (    )			
Specialty Provider	Telephone No. (    )			
Specialty Provider	Telephone No. (    )			
Diagnosis(es)				
Allergies				
ROUTINE CARE				
Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects
List medications given at home:				
NEEDED ACCOMMODATION(S)				
Describe any needed accommodation(s) the child needs in daily activities and why:				
Diet or Feeding: _____				
Classroom Activities: _____				
Naptime/Sleeping: _____				
Toileting: _____				
Outdoor or Field Trips: _____				
Transportation: _____				
Other: _____				
Additional comments: _____				
_____				



CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS  
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

\_\_\_\_\_

\_\_\_\_\_

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

\_\_\_\_\_

\_\_\_\_\_

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SUGGESTED SPECIAL TRAINING FOR STAFF

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health Care Provider Signature	Date
--------------------------------	------

PARENT NOTES (OPTIONAL)

\_\_\_\_\_

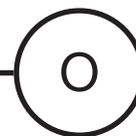
\_\_\_\_\_

\_\_\_\_\_

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date
---------------------------	------

**Important:** In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.



### Special Health Care Plan

The special health care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on appropriately accommodating the special health concerns and needs of this child while in child care.

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name: \_\_\_\_\_

.....  
**Description of condition(s):** (include description of difficulties associated with each condition) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Team Member Names and Titles** (parents of the child are to be included)

Care Coordinator (responsible for developing and administering the Special Health Care Plan): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

① If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached     Individualized Education Plan (IEP) attached

**Outside Professionals Involved**

**Telephone**

Health Care Provider (MD, NP, etc.): \_\_\_\_\_

Speech & Language Therapist: \_\_\_\_\_

Occupational Therapist: \_\_\_\_\_

Physical Therapist: \_\_\_\_\_

Psychologist/Mental Health Consultant: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Family-Child Advocate: \_\_\_\_\_

Other: \_\_\_\_\_

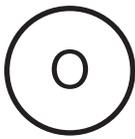
**Communication**

How the team will communicate (notes, communication log, phone calls, meetings, etc.):

\_\_\_\_\_  
\_\_\_\_\_

How often will team communication occur:     Daily     Weekly     Monthly     Bi-monthly     Other \_\_\_\_\_

Date and time specifics: \_\_\_\_\_



**Specific Medical Information**

\* Medical documentation provided and attached:  Yes  No

**Information Exchange Form** completed by health care provider is in child's file on site.

\* Medication to be administered:  Yes  No

**Medication Administration Form** completed by health care provider and parents are in child's file on site (including: type of medications, method, amount, time schedule, potential side effects, etc.)

Any known allergies to foods and/or medications: \_\_\_\_\_

Specific health-related needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Planned strategies to support the child's needs and any safety issues while in child care: (diapering/toileting, outdoor play, circle time, nap/sleeping, etc.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plan for absences of personnel trained and responsible for health-related procedure(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other (i.e., transportation, field trips, etc.): \_\_\_\_\_

\_\_\_\_\_

**Special Staff Training Needs**

Training monitored by: \_\_\_\_\_

1) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

2) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

3) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Equipment/Positioning**

\* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided:  Yes  No  Not Needed

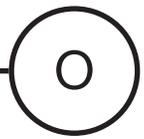
Special equipment needed/to be used: \_\_\_\_\_

\_\_\_\_\_

Positioning requirements (attach additional documentation as necessary): \_\_\_\_\_

\_\_\_\_\_

Equipment care/maintenance notes: \_\_\_\_\_



**Nutrition and Feeding Needs**

**Nutrition and Feeding Care Plan Form** completed by team is in child's file on-site. (See for detailed requirements/needs.)

**Behavior Changes** (be specific when listing changes in behavior that arise as a result of the health-related condition/concerns)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional Information** (include any unusual episodes that might arise while in care and how the situation should be handled)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Support Programs the Child Is Involved with Outside of Child Care**

1. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Address and telephone: \_\_\_\_\_  
Frequency of attendance: \_\_\_\_\_

2. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Address and telephone: \_\_\_\_\_  
Frequency of attendance: \_\_\_\_\_



3. Name of program: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Address and telephone: \_\_\_\_\_  
Frequency of attendance: \_\_\_\_\_

**Emergency Procedures**

Special emergency and/or medical procedure required (additional documentation attached)

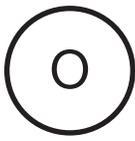
Emergency instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Follow-up: Updates/Revisions**

This Special Health Care Plan is to be updated/revised whenever child's health status changes or at least every \_\_\_\_\_ months as a result of the collective input from team members.

Due date for revision and team meeting: \_\_\_\_\_



### Nutrition and Feeding Care Plan

The nutrition and feeding care plan defines all members of the care team, communication guidelines (how, when, and how often), and all information on a child’s diet and feeding needs for this child while in child care.

**Name of Child:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Facility Name:** \_\_\_\_\_

.....  
**Team Member Names and Titles** (parents of the child are to be included)

Care Coordinator (responsible for developing and administering *Nutrition and Feeding Care Plan*): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ⓘ If training is necessary, then all team members will be trained.

Individualized Family Service Plan (IFSP) attached       Individualized Education Plan (IEP) attached

**Communication**

What is the team’s communication goal and how will it be achieved (notes, communication log, phone calls, meetings, etc.):

\_\_\_\_\_  
\_\_\_\_\_

How often will team communication occur:  Daily    Weekly    Monthly    Bi-monthly    Other \_\_\_\_\_

Date and time specifics: \_\_\_\_\_

**Specific Diet Information**

\* Medical documentation provided and attached:    Yes    No    Not Needed

Specific nutrition/feeding-related needs and any safety issues: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\* **Foods to avoid (allergies and/or intolerances):** \_\_\_\_\_

Planned strategies to support the child’s needs: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Plan for absences of personnel trained and responsible for nutrition/feeding-related procedure(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\* Food texture/consistency needs: \_\_\_\_\_

\* Special dietary needs: \_\_\_\_\_

\* Other: \_\_\_\_\_

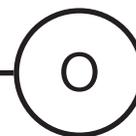
**Eating Equipment/Positioning**

\* Physical Therapist (PT) and/or Occupational Therapist (OT) consult provided    Yes    No    Not Needed

Special equipment needed: \_\_\_\_\_

Specific body positioning for feeding (attach additional documentation as necessary): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**Behavior Changes** (be specific when listing changes in behavior that arise before, during, or after feeding/eating)

\_\_\_\_\_  
\_\_\_\_\_

**Medical Information**

**Information Exchange Form** completed by Health Care Provider is in child's file onsite.

\* Medication to be administered as part of feeding routine:  Yes  No

**Medication Administration Form** completed by health care provider and parents is in child's file on-site (including type of medication, who administers, when administered, potential side effects, etc.)

**Tube Feeding Information**

Primary person responsible for daily feeding: \_\_\_\_\_

Additional person to support feeding: \_\_\_\_\_

Breast Milk  Formula (list brand information): \_\_\_\_\_

Time(s) of day: \_\_\_\_\_

Volume (how much to feed): \_\_\_\_\_ Rate of flow: \_\_\_\_\_ Length of feeding: \_\_\_\_\_

Position of child: \_\_\_\_\_

Oral feeding and/or stimulation (attach detailed instructions as necessary): \_\_\_\_\_

**Special Training Needed by Staff**

Training monitored by: \_\_\_\_\_

1) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

2) Type (be specific): \_\_\_\_\_

Training done by: \_\_\_\_\_ Date of Training: \_\_\_\_\_

**Additional Information** (include any unusual episodes that might arise while in care and how the situation should be handled)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Procedures**

Special emergency and/or medical procedure required (additional documentation attached)

Emergency instructions: \_\_\_\_\_

\_\_\_\_\_

Emergency contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Follow-up: Updates/Revisions**

This Nutrition and Feeding Care Plan is to be updated/revised whenever child's health status changes or at least every \_\_\_ months as a result of the collective input from team members.

Due date for revision and team meeting: \_\_\_\_\_





## Individual Health Care Plan for a Child with Special Health Care Needs

Working in collaboration with the child’s parent/guardian and child’s health care provider, the following health care plan was developed to meet the individual needs of:

<b>Child’s name:</b>	<b>Child’s date of birth:</b>
<b>Name of the child’s health care provider:</b> <div style="float: right; margin-top: 5px;"> <input type="checkbox"/> <b>Physician</b>  <input type="checkbox"/> <b>Physician Assistant</b>  <input type="checkbox"/> <b>Nurse Practitioner</b> </div>	

**Describe the special health care needs of this child and the plan of care as identified by the parent and the child’s health care provider. This should include information completed on the Medical Statement at the time of enrollment or information shared post enrollment.**


**Identify the program staff who will provide care to this child with special health care needs:**

Name	Credentials or Professional License Information*



**Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the Medical Statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.**


**Signature of Authorized Program Representative:**

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. \*I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name:	Facility address:	Facility Telephone Number:
Authorized child care provider's name (please print)		Date:
Authorized child care provider's signature:		

**Signature of Parent or Guardian:**

	Date:
--	-------

**Signature of Health Care Provider:**

	Date:
--	-------

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **Parent MUST complete #1-#17 and #20-#23 for medication to be administered 10 days or less.**
- Parent may complete #1- #15 for over-the-counter topical ointments, sunscreen & topically applied insect repellent
- **The child's health care provider MUST complete #1-#18 for medication to be administered more than 10 days, PRN ("as needed") medications and when dosage directions state "consult a physician", and parent must complete #20-#23.**

1. <b><u>CHILD's first and last name:</u></b>	2. Date of birth:	3. Child's known allergies:
4. <b><u>Name of MEDICATION:</u></b> (including strength):	5. <b><u>Amount/DOSAGE to be given:</u></b>	6. <b><u>ROUTE of administration:</u></b>
7A. <b><u>FREQUENCY:</u></b> _____ <b><u>Specific TIME(s)</u></b> (e.g. 1p.m.): _____ <b><u>to administer</u></b> _____ <i>Parent's signature approving Specific Time(s)</i> _____ OR		
7B. Identify the <b><u>symptoms that will necessitate administration</u></b> of medication: (signs and symptoms must be observable and, when possible, measurable parameters)		
8. <b>Possible side effects:</b> <input type="checkbox"/> See package insert (parent must supply) <i>AND/OR</i> additional side effects:		
9. What action should the child care provider take if side effects are noted: <input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe):		
10. <b>Special instructions:</b> <input type="checkbox"/> See package insert (parent must supply) <i>AND/OR</i> Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____		
11. <b>Reason the child is taking the medication</b> (unless confidential by law):		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #26-#28 on the back of this form.		
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #27-#28 on the back of this form.		
14. <b><u>Date consent form completed:</u></b>	15. <b><u>Date to be discontinued or length of time in days to be given</u></b> (this date cannot exceed 12 months from the date authorized or this order will not be valid):	
16. <b>Prescriber's name</b> (please print):	17. <b>Prescriber's telephone number:</b>	
18. <b>Licensed authorized prescriber's signature:</b> Required for Long-Term medications, PRN "as needed" medications and when dosage directions state "consult a physician".		

**PARENT/GUARDIAN MUST COMPLETE THIS SECTION (#20 - #23)**

20. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to _____ (child's name) .	
21. Parent or legal guardian's name (please print):	22. Date authorized:
23. Parent or legal guardian's signature:	

**PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15**

24. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ . Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed. (date)
25. Parent or Legal Guardian's Signature:

**LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#26 - #28)**

26. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
27. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE: _____ By completing this section the day care program will follow the written instruction on this form and <i>not</i> follow the pharmacy label until the new prescription has been filled.
28. Licensed Authorized Prescriber's Signature:

**DAY CARE PROGRAM TO COMPLETE THIS SECTION (#29 - #33)**

29. Provider/Facility name:	30. Facility ID number:
I have verified that #1-#23 and, if applicable, #26-#28 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
31. Authorized child care provider's name (please print):	32. Date received from parent:
33. Authorized child care provider's signature:	



Medication Administration Training for Child Day Programs

### Diabetes/Seizure Emergency Medication Telephone Consent Form

If emergency treatment must be given to a child immediately, and written consent cannot be obtained, the following form may be used to obtain informed consent by telephone. Telephone consent should be used as a “last resort” measure when written consent is not possible.

Child’s name: \_\_\_\_\_

#### Individuals authorized to approve emergency treatment:

Name	Relationship to child	Phone Number(s)

Date & Time	Reason for emergency medication/ symptoms	Name of Healthcare Provider contacted	Name of Authorized individual contacted	Relationship verified?	Symptoms explained?	Intended intervention explained?	Consent given?





## Permission to Self-Carry and Self-Administer Diabetes Care

To be completed by physician/health care provider and parent/guardian. This is a sample form.

Child's Name and DOB: \_\_\_\_\_

Child Day Program: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

Child's physician or other relevant licensed health care provider confirms that the child has a diagnosis of diabetes, is independent and can perform diabetes care, and has approval to self-administer his/her diabetes care including:

- Glucose monitoring
- Insulin calculation and administration (including pump operation and pump equipment)

The child understands that he/she is to promptly report to a MAT Diabetes certified staff member, qualified health care professional or other responsible adult as soon as symptoms of high or low blood glucose appear or when not feeling well.

I agree to prepare a written Diabetes Medical Management Plan (DMMP) in consultation with the child's parents and appropriate personnel.

Specific duration of order:	Physician/Health Care Provider Signature:	Office Phone:
	Provider Printed Name:	Office Fax:
		Date:

**My child has been instructed in and understands his/her diabetic self-management. My child understands that he/she is responsible and accountable for carrying and using his/her medication and equipment.**

**I will provide the child day program director/administrator/family day home with a copy of my child's Diabetes Medical Management Plan (DMMP) signed by his/her physician.**

**I hereby give permission for the child day program to administer the medications as prescribed in the care plan, if indicated (i.e., child requests assistance or becomes unable to perform self-care).**

**I also give permission for the child day program to contact the above physician/health care provider regarding my child's diabetes care.**

**I will not hold the child day program or any of its employees liable for any negative outcomes resulting from the self-administration of diabetes medication by my child.**

**I understand that the child day program director/administrator/family day home, after consultation with the parent/guardian, may impose reasonable limitations or restrictions upon my child's possession and self-administration of diabetes medications relative to his/her age and maturity or other relevant considerations.**

**I understand that the child day program may revoke permission to possess and self-administer said diabetes medication at any point if it is determined that my child has abused the privilege of possession and self-administration or he/she is not safely and effectively self-administering the medication. In addition, my child could be subject to further disciplinary action.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child Signature

\_\_\_\_\_  
Date





## Diabetes Treatment Self-Administration Assessment Form

### *Why Is Diabetes Self-Management Important?*

Diabetes care depends upon self-management. The child's competence and capability for performing diabetes-related care tasks should be specified in the Diabetes Medical Management Plan (DMMP) and then applied to the child day program setting by the administrative team, as outlined in the student's Individualized Health Care Plan.

Although children must receive assistance with and supervision of their diabetes care when needed, it is equally important to enable children to take on the responsibility of diabetes self-management with ongoing guidance and support from the parents/guardian, the child's health care provider, and the child day program. The age for transfer of responsibility from caregiver to child varies from child to child and from task to task because children develop and mature at different rates.

Children's abilities to participate in self-care also depend upon their willingness to do so. Although the ages at which children are able to perform diabetes care tasks are highly individualized and differ for each child, their ability and levels of self-care generally occur as follows:

- *Toddlers and preschool-aged children* are unable to perform diabetes care tasks independently and will need an adult to provide all aspects of diabetes care. Many of these young children will have difficulty recognizing hypoglycemia, so it is important that the caregiver be able to recognize and provide prompt treatment. Children in this age range, however, usually can determine which finger to prick, choose an injection site, and are generally cooperative. The child's health care provider and child day program must be aware of emotional and behavioral issues and refer children with diabetes and their families for counseling and support as needed.
- *Elementary school-aged children* often are able to perform their own blood glucose monitoring, but usually will require supervision. Older elementary school-aged children are beginning to self-administer insulin with supervision and understand the impact of insulin, physical activity, and nutrition on blood glucose levels. Unless children have hypoglycemic unawareness (inability to tell when their blood glucose level is low), most should be able to let an adult know when they are experiencing hypoglycemia. Middle- and high school-aged children should be able to provide self-care depending upon the length of time since diagnosis and level of maturity, but they always will need help when experiencing hypoglycemia.

As older children mature, they should be encouraged and empowered to perform diabetes care tasks on their own. Ultimately, each person with diabetes becomes responsible for all aspects of self-care, including blood glucose monitoring and insulin administration. Regardless of their level of self-management, however, all children with diabetes may require assistance when blood glucose levels are out of the target range. Regardless of their age, there are times when all children who have diabetes need someone else to share in their diabetes care tasks.

**The Program Administrator/Director should complete the following assessment upon enrollment:**

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Program Name:** \_\_\_\_\_ **Date of Enrollment:** \_\_\_\_\_

**Child's self-care blood glucose checking skills:**

- Independently checks own blood glucose
- May check blood glucose with supervision
- Requires child day program administrator/director or certified diabetes MAT personnel to check blood glucose

**Child's self-care insulin administration skills:**

- Yes  No Independently calculates and give own injections
- Yes  No May calculate/give own injections with supervision
- Yes  No Requires child day program administrator/director or certified diabetes MAT personnel to calculate/give injections

**Child's self-care pump skills:**

**Independent?**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Counts carbohydrates                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bolus correct amount for carbohydrates consumed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and administer correction bolus       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set basal profiles                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Calculate and set temporary basal rate          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change batteries                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Disconnect pump                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Reconnect pump to infusion set                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prepare reservoir and tubing                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Insert infusion set                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Troubleshoot alarms and malfunctions            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Child's self-care nutrition skills:**

- Yes  No Independently counts carbohydrates
- Yes  No May count carbohydrates with supervision
- Yes  No Requires child day program administrator/director or certified diabetes MAT personnel to count carbohydrates

Signature:

Date:

Program

Representative: \_\_\_\_\_

Parent/ Guardian: \_\_\_\_\_



## Age Appropriate Diabetes Self-Care Guidelines

Each child is unique in his or her ability to perform self-care tasks. Various factors such as age of diagnosis, child’s current developmental level, and the willingness on the part of the child and parent/guardian can influence the age at which the child assumes various self-care tasks.

<b>Toddlers and Preschool-Aged Children</b>	<b>Elementary School-Aged Children</b>	<b>Middle and High School-Aged Children</b>
<ul style="list-style-type: none"> <li>○ are usually unable to perform diabetes care tasks independently.</li> <li>○ need an adult to provide all or most aspects of care.</li> <li>○ can usually determine which finger to prick, choose an injection site, and are generally cooperative.</li> <li>○ aged 4 to 5 can collect own urine for ketone check, turn on glucometer, pinch their own skin, help with recording results, and begin to identify symptoms of low blood glucose.</li> </ul>	<ul style="list-style-type: none"> <li>○ may be able to perform their own blood glucose checks, but still need adult supervision.</li> <li>○ begin to learn, with adult supervision, some self-care tasks such as insulin administration by syringe or pump, meal planning with recognition of foods that contain carbs, carb counting, ketone testing, and record keeping related to self-care tasks.</li> <li>○ begin to understand the impact of insulin, physical activity, and nutrition on blood glucose levels.</li> <li>○ unless they have an inability to recognize symptoms of low blood glucose, should be able to recognize and tell an adult they feel symptomatic.</li> </ul>	<ul style="list-style-type: none"> <li>○ are usually able to provide self-care, depending on the length of diagnosis and the level of maturity.</li> <li>○ should be encouraged and empowered to be independent with self-care. *will need help if experiencing a low blood glucose.</li> </ul>





**Disposal or Return of Medications Log**

Child's Name: \_\_\_\_\_

Child Day Program Name: \_\_\_\_\_

Date	Name of Medication	Disposed or Returned?		Amount	Method of Disposal
		<i>Please circle</i>			
		<i>Disposed</i>	<i>Returned</i>		
		Parent/Guardian Signature (if returned):			
Date	Name of Medication	Disposed or Returned?		Amount	Method of Disposal
		<i>Please circle</i>			
		<i>Disposed</i>	<i>Returned</i>		
		Parent/Guardian Signature (if returned):			
Date	Name of Medication	Disposed or Returned?		Amount	Method of Disposal
		<i>Please circle</i>			
		<i>Disposed</i>	<i>Returned</i>		
		Parent/Guardian Signature (if returned):			





This plan should be completed by the child's personal diabetes health care team, including the parents/guardian. It should be reviewed with relevant program staff and copies should be kept in a place that can be accessed easily by the program nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: 10/16/CY This plan is valid for the current year: CY-NY

Child's Name: Candy Sweet Date of Birth: 5/27/CY-4

Date of Diabetes Diagnosis: 8/4/CY  type 1  type 2  Other

Program: Angel Babies Program Phone Number: 555-555-5555

Age Group: Three Year Old Class Classroom Teacher: JoAnn Duffy

MAT Diabetes certified staff or other qualified health care professional:

Cindy Brooks, Chris Mills

Phone: 555-555-5555

### CONTACT INFORMATION

Mother/Guardian: Katie Sweet

Address: 9516 Kensington Place

Telephone: Home 555-555-5555 Work 555-555-5555 Cell: 555-555-5555

Email Address: Katiesweet@gmail.com

Father/ Guardian: Dave Sweet

Address: 9516 Kensington Place

Telephone: Home 555-555-5555 Work 555-555-5555 Cell: 555-555-5555

Email Address: DSweet@gmail.com

Child's Physician/Health Care Provider: Dr. Harry Kraft

Address: 2038 Cary St., Richmond, VA 23226

Telephone: 555-555-5555

Email Address: HKraft@gmail.com Emergency Number: 555-555-5555

Other Emergency Contacts:

Name: Michael Matthews Relationship: Uncle

Telephone: Home 555-555-5555 Work 555-555-5555 Cell: 555-555-5555



**CHECKING BLOOD GLUCOSE**

Target range of blood glucose: \_\_\_\_\_  70-130 mg/dL  70-180 mg/dL

Other: \_\_\_\_\_

Check blood glucose level:  Before lunch  \_\_\_ Hours after lunch

2 hours after a correction dose  Mid-morning  Before physical activity (PE)  After PE

Before dismissal  Other: \_\_\_\_\_

As needed for signs/ symptoms of low or high blood glucose

As needed for signs/ symptoms of illness

Preferred site of testing:  Fingertip  Forearm  Thigh  Other:

Brand/Model of blood glucose meter: One Touch

*Note: The fingertip should always be used to check blood glucose level if hypoglycemia is suspected.*

**Child’s self-care blood glucose checking skills:**

Independently checks own blood glucose

May check blood glucose with supervision

Requires child day program administrator/director or MAT Diabetes certified staff to check blood glucose

**Continuous Glucose Monitor (CGM):**  Yes  No

Brand/Model: \_\_\_\_\_ Alarms set for:  (low) and  (high)

*Note: Confirm CGM results with blood glucose meter check before taking action on sensor blood glucose level. If child has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.*

**HYPOGLYCEMIA TREATMENT**

Child’s usual symptoms of hypoglycemia (list below):

Fatigue, irritability

If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than 60 mg/dL, give a quick-acting glucose product equal to 15 grams of carbohydrate.

Recheck blood glucose in 10-15 minutes and repeat treatment if blood glucose level is less than 70 mg/dL.

Additional treatment: Give Glucagon for blood glucose under 40 mg/dL and call emergency medical services for transport to hospital

**HYPOGLYCEMIA TREATMENT (Continued)**

Follow physical activity and sports orders (see page 7).

- If the child is unable to eat or drink, is unconscious or unresponsive, or is having seizures activity or convulsions (jerking movements), give:
- Glucagon:  1 mg  ½ mg Route:  SC(subcutaneous)  IM(intramuscular)
- Site for glucagon injection:  arm  thigh  Other: \_\_\_\_\_
- If blood glucose < 40, call 911 (Emergency Medical Services), the child's health care provider, and the child's parents/guardian.
- If blood glucose < 60 but greater than 40, notify the child's parents/guardian.

**HYPERGLYCEMIA TREATMENT**

Child's usual symptoms of hyperglycemia (list below):

Excessive thirst

---

---

Check  Urine  Blood for ketones every 2 hours when blood glucose levels are above 300 mg/dL.

For blood glucose greater than 180 mg/dL AND at least 2 hours since last insulin dose, give correction dose of insulin (see orders below).

For insulin pump users: see additional information for a child with insulin pump.

Give extra water and/or non-sugar-containing drinks (not fruit juices): 4 ounces per hour.

Additional treatment for ketones: Call physician if ketones are moderate to large

---

Follow physical activity and sports orders (see page 7).

- Notify parents/guardian of onset of hyperglycemia.
- If the child has symptoms of hyperglycemia emergency, including dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness: Call 911 (Emergency Medical Services) and the child's parents/guardian.
- Contact child's health care provider.

**Insulin therapy**

Insulin delivery device:  syringe  insulin pen  insulin pump

Type of insulin therapy at the child day program:

- Adjustable Insulin Therapy  
 Fixed Insulin Therapy  
 No insulin

**Adjustable Insulin Therapy**

- **Carbohydrate Coverage/ Correction Dose:**

Name of insulin: Humalog

**Meal Matrix** (*see Correction Matrix for Dosage Adjustments*)

Meal	Grams Carbs	Insulin Dose in Units	Meal	Grams Carbs	Insulin Dose in Units
Meatloaf lunch	40	3			
Pizza lunch	30	2			
Roast chicken lunch	20	1			

- **Carbohydrate Coverage:**

Insulin-to-Carbohydrate Ratio: 1:15

Lunch: 1 unit of insulin per 15 grams of carbohydrate

Snack: 1 unit of insulin per 15 grams of carbohydrate

**Carbohydrate Dose Calculation Example**

$$\frac{\underline{60} \text{ Grams of carbohydrate in meal}}{\underline{15} \text{ Insulin-to-carbohydrate ratio}} = \underline{4} \text{ units of insulin}$$

**Correction dose matrix** (use instead of calculation below to determine insulin correction dose):

Blood Glucose	Correction Dose in Units
<u>170</u> to <u>220</u> mg/dL	1
<u>220</u> to <u>270</u> mg/dL	2
<u>270</u> to <u>320</u> mg/dL	3
<u>320</u> to <u>370</u> mg/dL	4



• **Correction Dose:**

Blood Glucose Correction Factor/Insulin Sensitivity Factor= 1 unit insulin for each 50  
mg/dL above target Target blood glucose= 120 mg/dL

**Correction Dose Calculation Example**

220 Actual Blood Glucose – 120 Target Blood Glucose

50 Blood Glucose Correction Factor/Insulin Sensitivity Factor = 2 units of insulin

**When to give insulin:**

Lunch

- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than 180 mg/dL and 3 hours since last insulin dose.
- Other: \_\_\_\_\_

Snack

- No coverage for snack
- Carbohydrate coverage only
- Carbohydrate coverage plus correction dose when blood glucose is greater than 180 mg/dL and 2 hours since last insulin dose.
- Correction dose only:  
For blood glucose greater than \_\_\_\_\_ mg/dL AND at least \_\_\_\_\_ hours since last insulin dose.
- Other: \_\_\_\_\_

**Fixed Insulin Therapy**

Name of insulin: n/a

- \_\_\_\_\_ Units of insulin given pre-lunch daily
- \_\_\_\_\_ Units of insulin given pre-snack daily
- Other: \_\_\_\_\_



**Parent Authorization to Adjust Insulin Dose:**

- Yes     No    Parents/guardian authorization should be obtained before administering a correction dose.
- Yes     No    Parents/guardian are authorized to increase or decrease correction dose scale within the following range: +/- \_\_\_\_ units of insulin
- Yes     No    Parents/guardian are authorized to increase or decrease insulin-to-carbohydrate ratio within the following range: \_\_\_\_ units per prescribed grams of carbohydrate, +/- \_\_\_\_ grams of carbohydrate.
- Yes     No    Parents/guardian are authorized to increase or decrease fixed insulin dose within the following range: +/- \_\_\_\_ units of insulin.

**Child’s self-care insulin administration skills:**

- Yes     No    Independently calculates and give own injections
- Yes     No    May calculate/give own injections with supervision
- Yes     No    Requires MAT Diabetes certified staff to calculate/give injections

**ADDITIONAL INFORMATION FOR CHILD WITH INSULIN PUMP**

Brand/Model of pump   n/a   Type of insulin in pump: \_\_\_\_\_

Basal rates during program: \_\_\_\_\_

Type of infusion set: \_\_\_\_\_

- For blood glucose greater than \_\_\_\_ mg/dL that has not decreased within \_\_\_\_ hours after correction, consider pump failure or infusion site failure. Notify parents/guardian.
- For infusion site failure: Insert new fusion set and/ or replace reservoir.
- For suspected pump failure: suspend or remove pump and give insulin by syringe or pen.

**Physical Activity**

- May disconnect from pump for sports activities     Yes     No
- Set a temporary basal rate     Yes     No    % temporary basal for \_\_\_\_\_ hours
- Suspend pump use     Yes     No



Independent?

Child's self-care pump skills:

- Counts carbohydrates  Yes  No
- Bolus correct amount for carbohydrates consumed  Yes  No
- Calculate and administer correction bolus  Yes  No
- Calculate and set basal profiles  Yes  No
- Calculate and set temporary basal rate  Yes  No
- Change batteries  Yes  No
- Disconnect pump  Yes  No
- Reconnect pump to infusion set  Yes  No
- Prepare reservoir and tubing  Yes  No
- Insert infusion set  Yes  No
- Troubleshoot alarms and malfunctions  Yes  No

OTHER DIABETES MEDICATIONS

Name: n/a Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Times given: \_\_\_\_\_

MEAL PLAN

Meal/Snack	Time	Carbohydrate Content (grams)
Breakfast	<u>7:30am</u>	<u>15</u> to <u>30</u>
Mid-morning snack	<u>10:00 am</u>	<u>7</u> to <u>15</u>
Lunch	<u>12:00pm</u>	<u>15</u> to <u>30</u>
Mid-afternoon snack	<u>3:00 pm</u>	<u>7</u> to <u>15</u>

Other times to give snacks and content/amount: n/a

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

- Special event/party food permitted:  Parents/guardian discretion  
 Child discretion

**Child's self-care nutrition skills:**

- Yes  No Independently counts carbohydrates
- Yes  No May count carbohydrates with supervision
- Yes  No Requires MAT Diabetes certified staff or other qualified health care professional to count carbohydrates

**PHYSICAL ACTIVITY AND SPORTS**

A quick-acting source of glucose such as  glucose tabs and/or  sugar-containing juice must be available at the site of physical education activities and sports.

Child should eat  15 grams  30 grams of carbohydrates  other  before  every 30 minutes during  after vigorous physical activity  other: \_\_\_\_\_

If most recent blood glucose is less than 180 mg/dL, test before exercise. Child can participate in physical activity when blood glucose above 100 mg/dL.

Avoid physical activity when blood glucose is greater than 300 mg/dL or if urine/blood ketones are moderate to large.

(Additional information for child on insulin pump is in the insulin section on page 6.)

**DISASTER PLAN**

To prepare for an unplanned disaster or emergency (72 HOURS), obtain emergency supply kit from parent/guardian.

- Continue to follow orders contained in this DMMP.
- Additional insulin orders as follows: \_\_\_\_\_
- Other: \_\_\_\_\_



**SIGNATURES**

This Diabetes Medical Management Plan has been approved by:

Child’s Physician/Health Care Provider: Harry Kraft, MD

Date: 10/16/CY

I, (parent/guardian:) Dave Sweet give permission to the MAT Diabetes certified staff or other qualified health care professional of (program:) Angel Babies to perform and carry out the diabetes care tasks as outlined in (child:) Candy Sweet’s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all program staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I also give permission to the MAT Diabetes certified staff or other qualified health care professional to contact my child’s physician/health care provider.

Acknowledged and received by:

Dave Sweet 10/16/CY  
Child’s Parent/Guardian Date

\_\_\_\_\_  
Child’s Parent/Guardian Date

Chris Mills 10/16/CY  
MAT Diabetes Certified Staff/Other Qualified Health Care Personnel Date



### III. Virginia School Diabetes Medical Management Forms

Student Candy Sweet Program Angel Babies Effective Date 10/16/CY

Date of Birth 5/27/CY-8 Age Group 3 year old class Homeroom Teacher JoAnn Duffy

Dear Parent/Guardian:

1. **Part 1-** Medical history and contact information. To be completed by parent/guardian. Includes: Parent authorization for trained school designees. To be completed by parent/guardian.
2. **Part 2\*-** Have your child’s physician complete unless the physician’s office prefers to use his/her own *Diabetes Medical Management Plan*. Please note that physician authorization for treatment by trained school designees must be included in the Diabetes Medical Management Plan or a separate form must be provided.
3. **Part 3\*-** Have the physician/diabetes educator/caregiver complete if your child wears an insulin pump.
4. **Part 4-** If your child is going to carry and self administer insulin and perform blood sugar checks in the classroom; an “*Authorization to Carry and Self-Administer Medication Form*” must be completed by the physician, school nurse and the parent.

\*Other Diabetic Medical Management Plans may be used for **Parts 2 & 3** as long as all components are represented.

Return completed forms as quickly as possible. Thank you for your cooperation.

**MAT Diabetes Certified Provider** Chris Mills Phone 555-555-5555 Date 10/16/CY

Please note: during the school year, in order to change your child’s diabetes care at school, an updated physician’s order must be submitted to the school nurse.

#### Part 1: Parent/Guardian to complete:

##### Contact Information:

Parent/Guardian #1: Katie Sweet

Address: 9516 Kensington Place, Richmond VA 23518

Telephone-Home: 555-555-5555 Work: 555-555-5555 Cell: 555-555-5555

Parent/Guardian #2: Dave Sweet

Address: 9516 Kensington Place, Richmond VA 23518

Telephone-Home: 555-555-5555 Work: 555-555-5555 Cell: 555-555-5555

Other emergency contact: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone-Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Physician managing diabetes: Harry Kraft, MD

Address: 2038 Cary St, Richmond VA 24321

Main Office # 555-555-5555 Fax # 555-555-5555 Emergency Phone # 555-555-5555

Nurse/Diabetes Educator \_\_\_\_\_ Work # \_\_\_\_\_

<b>Diabetes Questions</b>	<b>Parent/Guardian Response (check appropriate boxes and complete blanks)</b>
Diagnosis information	At what age? <u>3</u> Type of diabetes? <u>Type 1</u>
How often is child seen by this physician? <i>Include date last seen.</i>	<u>Every 6 months, last seen 9/16/CY</u>
Nutritional needs	Snack <input checked="" type="checkbox"/> <u>10</u> AM <input checked="" type="checkbox"/> <u>3</u> PM <input type="checkbox"/> _____ Prior to Exercise/Activity <input type="checkbox"/> Only in case of low blood glucose <input type="checkbox"/> Student may determine if CHO counting

	<input type="checkbox"/> In the event of a class party may eat the treat (include insulin coverage if indicated in medical orders) <input type="checkbox"/> student able to determine whether to eat the treat <input checked="" type="checkbox"/> replace with parent supplied treat <input type="checkbox"/> may NOT eat the treat <input type="checkbox"/> other <u>Contact parent before party to discuss</u>
Child's most common signs of low blood glucose	<input type="checkbox"/> trembling <input type="checkbox"/> tingling <input type="checkbox"/> loss of coordination <input type="checkbox"/> dizziness <input type="checkbox"/> moist skin/sweating <input type="checkbox"/> slurred speech <input type="checkbox"/> heart pounding <input type="checkbox"/> hunger <input type="checkbox"/> confusion <input type="checkbox"/> weakness <input checked="" type="checkbox"/> fatigue <input type="checkbox"/> seizure <input type="checkbox"/> pale skin <input type="checkbox"/> headache <input type="checkbox"/> unconsciousness <input type="checkbox"/> change in mood or behavior <input checked="" type="checkbox"/> other <u>irritability</u>
How often does child experience low blood glucose and how severe?	<b>Mild</b> <input type="checkbox"/> once a day <input checked="" type="checkbox"/> once a week <input type="checkbox"/> once a month Indicate date(s) of last mild episode(s) <u>10/7/CY</u>  <b>Severe</b> (i.e. unconscious, unable to swallow, seizure, or needed Glucagon) Include date(s) of recent episode(s) <u>n/a</u>
Episode(s) of ketoacidosis	Include date(s) of recent episode(s) <u>n/a</u>
Field trips	Parent/guardian will accompany child during field trips? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Yes, if available
Serious illness, injuries or hospitalizations this past year	Date(s) and describe: none
List any other medications currently being taken	none
Allergies (include foods, medications, etc):	none
Other concerns and comments	none

I give permission to the school nurse and designated school personnel\*, who have been trained and are under the supervision of the school nurse to perform and carry out the diabetes care tasks as outlined in my child's *Diabetes Medical Management Plan* as ordered by the physician. I give permission to the designated school personnel, who have been trained to perform the following diabetes care tasks for my child. (Code of Virginia§ 22.1-274).

Insulin Administration     YES       NO      Glucagon Administration     YES       NO

I understand that I am to provide all supplies to the school necessary for the treatment of my child's diabetes. I also consent to the release of information contained in the Diabetes Medical Management Plan to staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I also give permission to contact the above named physician and members of the diabetes management team regarding my child's diabetes should the need arise.

Parent/Guardian Name Katie Sweet      Date 10/16/CY

Parent/Guardian Signature *Katie Sweet*

**MAT Diabetes Certified Provider** Chris Mills      Date 10/16/CY

**MAT Diabetes Certified Provider's Signature** *Chris Mills*

**DIABETES MEDICAL MANAGEMENT PLAN  
CONVENTIONAL THERAPY or TYPE 2**

Patient Label or MRN, Acct#, Patient name, DOB, Date of Service

**Part 2: Virginia Diabetes Medical Management Plan (DMMP)**

To be completed by physician/provider.

Notice to Parents: Medication(s) **MUST** be brought to school by the PARENT/GUARDIAN in a container that is appropriately labeled by the pharmacy or physician/practitioner.

In order for schools to safely administer medication during school hours, the following guidelines should be observed:

- A new copy of the DMMP must be completed at the beginning of each school year. This form, an Authorization for Medication Administration form, or MD prescription must be received in order to change diabetes care at school during the school year.

<b>Student Name (Last, First, MI)</b> Sweet, Candy	<b>Student's Date of Birth</b> 5/27/CY-4	
<b>Child Day Program</b> KinderCare	<b>Student's Grade</b> 3 year old class	<b>Phone</b> 555-555-5555
<b>Parent Name</b> Katie Sweet	<b>Work/Cell Phone</b> 555-555-5555	
<b>Home Address</b> 9516 Kensington Place	<b>City</b> Richmond	<b>State, Zip code</b> VA 23232
<b>Student's Diagnosis: DIABETES:</b> <input checked="" type="checkbox"/> <b>Type 1</b> <input type="checkbox"/> <b>Type 2</b> <input type="checkbox"/> <b>Other</b> _____	<b>Today's Date</b> 10/16/CY	

<b>MONITORING</b>				
<b><u>BLOOD GLUCOSE (BG) MONITORING</u></b> with meter, lancets, lancing device, and test strips	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Student requires supervision <input checked="" type="checkbox"/> To be performed by school personnel <input type="checkbox"/> Student is independent <input type="checkbox"/> Permission to self-carry	<input checked="" type="checkbox"/> Before meals <input checked="" type="checkbox"/> For symptoms of hypo/hyperglycemia & anytime the student does not feel well <input type="checkbox"/> Before PE/Activity <input type="checkbox"/> After PE/Activity <input type="checkbox"/> Prior to dismissal <input checked="" type="checkbox"/> Additional BG monitoring may be performed at parent's request		
<b><u>CONTINUOUS GLUCOSE MONITORING (CGM)</u></b> <b>Brand/Model:</b> _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Alarms set for: Low: _____ (mg/dL) High: _____ (mg/dL)	Always confirm CGM results with finger stick check before taking action on sensor blood glucose level. If student has symptoms or signs of hypoglycemia, check finger stick blood glucose level regardless of CGM.		
<input checked="" type="checkbox"/> <b><u>URINE KETONE TESTING</u></b> <input type="checkbox"/> <b><u>BLOOD KETONE TESTING</u></b>	Anytime the <b>BG &gt; 300</b> mg/dL or when student complains of nausea, vomiting, abdominal pain. See page 3 for further instructions under hyperglycemia management.			
NAME OF MEDICATION	DOSE/ROUTE	TIME		
<input checked="" type="checkbox"/> <b><u>GLUCAGON</u></b> - INJECTABLE	<input checked="" type="checkbox"/> 0.5 mg subq/IM <input type="checkbox"/> 1mg subq/IM	Immediately for severe hypoglycemia: unconscious, semi-conscious (unable to control his/her airway or unable to swallow), or seizing		
ORAL MEDICATIONS	DOSAGE	TIME	POSSIBLE SIDE EFFECTS	TREATMENT SIDE EFFECTS
<input type="checkbox"/> Glucophage® (Metformin) <input type="checkbox"/> to be administered at school	_____ mg po	_____ AM or PM	Nausea/vomiting, diarrhea	Clear liquids
<input type="checkbox"/> Other: _____ <input type="checkbox"/> to be administered at school				
<input type="checkbox"/> Additional Instructions:				

Specific duration of order: <b>Until</b> <b>10/16/NY</b>	Physician/Provider Signature: <i>Harry Kraft, MD</i>	Provider Printed Name: Harry Kraft, MD	Office Phone: 555-555-5555 Office Fax: 555-555-5555
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**DIABETES MEDICAL MANAGEMENT PLAN  
CONVENTIONAL THERAPY or TYPE 2**

**DIABETES SCHOOL CARE PLAN  
CONVENTIONAL THERAPY OR TYPE 2 DIABETES**

**Student: Candy Sweet  
Effective date: 10/16/CY**

<b>INSULIN</b>			
Insulin to be given during school hours:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Student can administer insulin if supervised
<b>Insulin Types:</b> <input checked="" type="checkbox"/> Rapid-acting Insulin Type: <b>Humalog®</b> <input type="checkbox"/> Short-acting Insulin Type: <b>Regular</b>  <input type="checkbox"/> Intermediate-acting Insulin Type: <b>NPH</b> <input type="checkbox"/> may mix with rapid or short-acting insulin  <input type="checkbox"/> Long-acting Insulin Type: _____ units at _____ am or pm <input type="checkbox"/> may mix with rapid-acting insulin  (all doses to be administered subcutaneously)	<input type="checkbox"/> <b>Meal Plan:</b> <input checked="" type="checkbox"/> according to the following distribution: Breakfast: 15-30 grams AM Snack: 7-15 grams Lunch: 15-30 grams PM Snack: 7-15 grams  <input checked="" type="checkbox"/> Insulin:CHO Ratio: 1 unit for every 15 grams of CHO <input type="checkbox"/> decrease by 1 unit if pre-lunch reading is less than 80 mg/dL or if strenuous exercise is anticipated.		
<input type="checkbox"/> Pre-breakfast dose: Regular _____ units    Humalog® or Novolog® or Apidra® _____ units    NPH _____ units <input checked="" type="checkbox"/> Pre-lunch dose: Regular _____ units    Humalog® or Novolog® or Apidra® _____ units    NPH _____ units * SEE FOOTNOTE <input type="checkbox"/> Pre-dinner dose: Regular _____ units    Humalog® or Novolog® or Apidra® _____ units    NPH _____ units			
<input checked="" type="checkbox"/> <b>Sliding scale to be administered at prelunch (times)</b> <b>Correction Dose METHOD 1</b> If blood glucose                      Units of rapid-acting Insulin subq 170 to 220 mg/dL _____ give _____ 1 _____ 220 to 270 mg/dL _____ give _____ 2 _____ 270 to 320 mg/dL _____ give _____ 3 _____ 320 to 370 mg/dL _____ give _____ 4 _____ _____ give _____ _____ give _____	<input checked="" type="checkbox"/> <b>Insulin Sensitivity (Correction Factor) to be administered at prelunch (times) METHOD 2</b> <ul style="list-style-type: none"> <li>the predicted drop in blood glucose concentration after administration of 1 unit of regular or rapid-acting insulin</li> <li>usually expressed as "1 unit for every _50_mg/dL blood glucose is &gt; target"</li> <li>If uneven, then round to the nearest <b>half or whole unit</b> (May use clinical discretion; if physical activity follows meal, then may round down)</li> </ul> Sensitivity: 1 : 50 Target: 120 mg/dL		
<input checked="" type="checkbox"/> <b>Other Instructions:</b> Before lunch, follow instructions above. At other times, if blood glucose greater than 180 and at least 2 hours since last insulin dose, give correcting dose using either method above.			

**Snacks**

- Children using NPH insulin usually require snacks without additional insulin coverage (please, adhere to CHO amounts ordered above).
- Scheduled snacks may be required prior to or after exercise in order to prevent hypoglycemia. Insulin is not administered with these snacks.  

Before Exercise                       After Exercise                      X Per schedule above
- Foods may be eaten at unscheduled times. Insulin may be ordered for these snacks in order to prevent post-meal hyperglycemia (see above).
- Snack time insulin = # carbohydrates consumed/CHO Ratio.
- Never provide insulin coverage for carbohydrate/glucose being used to treat hypoglycemia.

**Exercise and Sports**

- In general, there are no restrictions on activity unless specified.
- A student should not exercise if his/her blood glucose is <100 mg/dL or > 300 mg/dL and ketones are positive.
- A source of fast-acting glucose & glucagon (if ordered) should be available in case of hypoglycemia.

Specific duration of order: <b>Until 10/16/NY</b>	Physician/Provider Signature: _____ <i>Harry Kraft, MD</i>	Provider Printed Name: Harry Kraft, MD	Office Phone: 555-555-5555 Office Fax: 555-555-5555
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\* PRELUNCH DOSE: 1 unit per 15 grams of carbs, plus correction dose if blood glucose is greater than 180 and at least 3 hours since last insulin dose. To calculate the correction dose, use Method 1 OR Method 2 above, but not both methods..

**DIABETES MEDICAL MANAGEMENT PLAN  
CONVENTIONAL THERAPY or TYPE 2**

Patient Label or MRN, Acct#, Patient Name, DOB, Date of Service

**DIABETES SCHOOL CARE PLAN**

**Student: Candy Sweet  
Effective date: 10/16/CY**

**Hypoglycemia (Low Blood Glucose)**

Hypoglycemia is defined as a blood glucose  $\leq$  60 mg/dL

Signs of hypoglycemia:

Hunger	Sweating	Shakiness	Paleness	Dizziness
Confusion	Loss of coordination	Fatigue	Fighting	Crying
Day-dreaming	Inability to concentrate	Anger	Passing-out	Seizure

- If hypoglycemia is suspected, check the blood glucose level.

<b>Hypoglycemia Management (Low Blood Glucose)</b>	<b>Severe Hypoglycemia: If student unconscious, semi-conscious (unable to control airway or unable to swallow), blood glucose less than 40 or seizing, administer glucagon.</b>
	<ul style="list-style-type: none"> <li>• Place student in the "recovery position."</li> <li>• If glucagon is administered, call 911 for emergency assistance, and call Parents/Legal Guardian.</li> </ul>
	<b>Mild or Moderate Hypoglycemia: If conscious &amp; able to swallow, immediately give 15 gram fast-acting glucose:</b>
	<ul style="list-style-type: none"> <li>• 3-4 glucose tablets or</li> <li>• 6 Life Saver® Candies or</li> <li>• 4 ounces of regular soda/juice or</li> <li>• 1 small tube Glucose/Cake gel</li> </ul>
	<b>Repeat BG check in 15 minutes</b>
	<ul style="list-style-type: none"> <li>• If BG still low, then re-treat with 15 gram CHO</li> <li>• If BG in acceptable range and at lunch or snack time, let student eat and cover CHO per orders</li> <li>• If BG in acceptable range and not lunch or snack time, provide student slowly-released CHO snack (3-4 peanut butter or cheese crackers or ½ sandwich)</li> </ul>
	If unable to raise the BG > 70 mg/dL despite fast-acting glucose sources, call parent.

**Hyperglycemia (High Blood Glucose)**

Signs of hyperglycemia:

Extreme thirst	Frequent urination	Blurry Vision	Hunger	Headache
Nausea	Hyperactivity	Dry Skin	Dizziness	Stomachache

- If hyperglycemia is suspected, check the blood glucose level.

<b>Hyperglycemia Management (High Blood Glucose)</b>	<b>If BG &gt; 300 mg/dL, or when child complains of nausea, vomiting, and/or abdominal pain, ask the student to check his/her urine for ketones</b>
	<ul style="list-style-type: none"> <li>• If urine ketones are trace or negative (blood ketones 0 - 1mmol/L), give 8-16 ounces of sugar-free fluid (water), return to classroom.</li> <li>• If correction insulin has not been administered within 3 hours, provide correction insulin according to student's Correction Factor and Target pre-meal BG</li> <li>• Recheck BG and ketones 2 hours after administering insulin</li> </ul>
	<ul style="list-style-type: none"> <li>• If urine ketones are moderate/large (blood ketones &gt; 1mmol/L), give 8-16 ounces of sugar-free fluid (water) and call for instructions concerning insulin administration.</li> <li>• Contact the Parent/Legal Guardian.</li> <li>• Recheck BG and ketones 2 hours after administering insulin</li> </ul>

My signature below provides authorization for the above written orders. I/We understand that all treatments and procedures may be performed by the school nurse, the student and / or trained unlicensed designated school personnel under the training and supervision provided by the school nurse (or by EMS in the event of loss of consciousness or seizure) in accordance with state laws & regulations. I also give permission for the school to contact the health care provider regarding these orders and administration of these medications.

School plan ordered by:	Physician/Provider Signature: <i>Harry Kraft, MD</i>	Provider Printed Name: Harry Kraft, MD	Date: 10/16/CY
Acknowledged and received by:	Parent/Legal Guardian: Katie Sweet		Date: 10/16/CY
Acknowledged and received by:	MAT Diabetes Certified Provider: Chris Mills		Date: 10/16/CY

**Meal Matrix** (see *Correction Matrix for Dosage Adjustments*)

Meal	Grams Carbs	Insulin Dose in Units	Meal	Grams Carbs	Insulin Dose in Units
Meatloaf lunch	40	3			
Pizza lunch	30	2			
Roast chicken lunch	20	1			



## Hypoglycemia Emergency Action Plan

(For Low Blood Glucose)

Child's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

### Emergency Contact Information

Mother/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Program Nurse: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

MAT Certified Personnel: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

**The child should never be left alone, or sent anywhere alone, or with another child, when experiencing hypoglycemia.**

Causes of Hypoglycemia	Onset of Hypoglycemia
<ul style="list-style-type: none"> <li>• Too much insulin</li> <li>• Missing or delaying meals or snacks</li> <li>• Not eating enough food (carbohydrates)</li> <li>• Getting extra, intense, or unplanned physical activity</li> <li>• Being ill, particularly with gastrointestinal illness</li> </ul>	<ul style="list-style-type: none"> <li>• Sudden-symptoms may progress rapidly</li> </ul>

**This is a double-sided form—highlighted sections on the back of the form must be completed**

Version 10/30/2016 - Adapted with permission from the NDEP document entitled, "Helping the Student with Diabetes Succeed – A Guide for School Personnel, Updated Edition 2010"

## Hypoglycemia Symptoms

Circle child's usual symptoms.

Mild to Moderate		Severe
<ul style="list-style-type: none"> <li>• Shaky or jittery</li> <li>• Sweaty</li> <li>• Hungry</li> <li>• Pale</li> <li>• Headache</li> <li>• Blurry vision</li> <li>• Sleepy</li> <li>• Dizzy</li> <li>• Confused</li> <li>• Disoriented</li> </ul>	<ul style="list-style-type: none"> <li>• Uncoordinated</li> <li>• Irritable or nervous</li> <li>• Argumentative</li> <li>• Combative</li> <li>• Changed personality</li> <li>• Changed behavior</li> <li>• Inability to concentrate</li> <li>• Weak</li> <li>• Lethargic</li> <li>• Other:</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to eat or drink</li> <li>• Unconscious</li> <li>• Unresponsive</li> <li>• Seizure activity or convulsions (jerking movements)</li> </ul>

## Actions for Treating Hypoglycemia

Notify Program Nurse or Trained Diabetes Personnel as soon as you observe symptoms.

If possible, check blood glucose (sugar) at fingertip.

Treat for hypoglycemia if blood glucose level is less than **\_\_\_ mg/dL**.

**WHEN IN DOUBT, ALWAYS TREAT FOR HYPOGLYCEMIA AS SPECIFIED BELOW.**

Treatment for Mild to Moderate Hypoglycemia	Treatment for Severe Hypoglycemia
<ul style="list-style-type: none"> <li>• Provide quick-acting glucose (sugar) product <b>equal to ___ grams</b> of carbohydrates. Example of 15 grams of carbohydrates include:               <ul style="list-style-type: none"> <li>○ 3 or 4 glucose tablets</li> <li>○ 1 tube of glucose gel</li> <li>○ 4 ounces of fruit juice (not low-calorie or reduced sugar)</li> <li>○ 6 ounces of soda (1/2 can) (not low-calorie or reduced sugar)</li> </ul> </li> <li>• Wait 10 to 15 minutes.</li> <li>• Recheck blood glucose level.</li> <li>• Repeat quick-acting glucose product if blood glucose level is less than <b>___ mg/dL</b>.</li> <li>• Contact the child's parents/guardian.</li> </ul>	<ul style="list-style-type: none"> <li>• Position the child on his or her side.</li> <li>• Do not attempt to give anything by mouth.</li> <li>• Administer glucagon: <b>___ mg</b> at site.</li> <li>• While treating, have another person call 911 (Emergency Medical Services).</li> <li>• Contact the child's parents/guardian.</li> <li>• Stay with the child until Emergency Medical Services arrive.</li> <li>• Notify child's health care provider.</li> </ul>



## Hyperglycemia Emergency Action Plan (For High Blood Glucose)

Child's Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date of Plan: \_\_\_\_\_

### Emergency Contact Information

Mother/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Email address: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Health Care Provider: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Program Nurse: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

MAT Certified Personnel: \_\_\_\_\_

Contact number(s): \_\_\_\_\_

Causes of Hyperglycemia	Onset of Hyperglycemia
<ul style="list-style-type: none"> <li>• Too little insulin or other glucose-lowering medication</li> <li>• Food intake that has not been covered adequately by insulin</li> <li>• Decreased physical activity</li> <li>• Illness</li> <li>• Infection</li> <li>• Injury</li> <li>• Severe physical or emotional stress</li> <li>• Pump malfunction</li> </ul>	<ul style="list-style-type: none"> <li>• Over several hours or days</li> </ul>

Hyperglycemia Signs	Hyperglycemia Emergency Symptoms  (Diabetic Ketoacidosis, DKA, which is associated with hyperglycemia, ketosis, and dehydration)
<b>Circle child's usual signs and symptoms.</b>	
<ul style="list-style-type: none"> <li>• Increased thirst and/or dry mouth</li> <li>• Frequent or increased urination</li> <li>• Change in appetite and/or nausea</li> <li>• Blurry vision</li> <li>• Fatigue</li> <li>• Other:</li> </ul>	<ul style="list-style-type: none"> <li>• Dry mouth, extreme thirst, and/or dehydration</li> <li>• Nausea and vomiting</li> <li>• Severe abdominal pain</li> <li>• Fruity breath</li> <li>• Heavy breathing or shortness of breath</li> <li>• Chest pain</li> <li>• Increased sleepiness or lethargy</li> <li>• Depressed level of consciousness</li> </ul>

<b>Actions for Treating Hyperglycemia</b>	
<b>Notify School Nurse or Trained Diabetes Personnel as soon as you observe symptoms.</b>	
Treatment for Hyperglycemia	Treatment for Hypoglycemia Emergency
<ul style="list-style-type: none"> <li>• Check the blood glucose level: <span style="background-color: yellow;">      </span> mg/dL.</li> <li>• Check urine or blood for ketones if blood glucose levels are greater than: <span style="background-color: yellow;">      </span> mg/dL.</li> <li>• If child uses a pump, check to see if pump is connected properly and functioning.</li> <li>• Administer supplemental insulin dose: <span style="background-color: yellow;">      </span>.</li> <li>• Give extra water or non-sugar-containing drinks (not fruit juices): <span style="background-color: yellow;">      </span> ounces per hour.</li> <li>• Allow free and unrestricted access to the restroom.</li> <li>• Recheck blood glucose every 2 hours to determine if decreasing to target range of <span style="background-color: yellow;">      </span> mg/dL.</li> <li>• Restrict participation in physical activity if blood glucose is greater than <span style="background-color: yellow;">      </span> mg/dL and if ketones are moderate to large.</li> <li>• Notify parents/guardian if ketones are present</li> </ul>	<ul style="list-style-type: none"> <li>• Call parents/guardian, child's health care provider, and 911 (Emergency Medical Services) right away.</li> <li>• Stay with the child until Emergency Medical Services arrive.</li> </ul>



## Diabetes Tips for Providers

It's important for providers to serve in a role of supporting children in their care with diabetes. This following list gives specific examples of how providers can foster healthy diabetes management within their program:

- Understand that all children with diabetes are different and react differently to symptoms of low BG.
- Try not to draw attention to the child's diabetes.
- Be inconspicuous in your reminders about snacks and self-care tasks.
- Do not label children with diabetes. Never refer to the child as the "diabetic kid."
- Do not sympathize. Empathize and learn what you can do to support the individual.
- Always be prepared and have an appropriate snack available. Take it with you whenever you leave the classroom.
- Never leave the child with diabetes alone if they are experiencing symptoms of a low blood glucose. If they need to go to the office or see the nurse, send an assistant with them.
- The child with diabetes needs unrestricted access to the bathroom and to water.
- Be patient, especially in situations where children have a low blood glucose. Variations in blood glucose levels can interfere with the child's ability to organize things or to concentrate.
- Knowledge is power. Educate yourself about diabetes and keep the lines of communication open.





### Carbohydrate Content of Common Foods

Although it's important to note that these carbohydrate counts can vary by brand and by method of preparation, these are general guidelines for the carbohydrate content of common foods:

Food	Grams of Carbohydrate	Exchanges
1 large plain bagel	47	3.1
1 slice bread	12 to 18	1
½ cup cooked pasta	15 to 20	1
½ cup cooked rice	21	1.4
2 tablespoons peanut butter	7	.5
1 tablespoon fruit jam (sugar-containing)*	15	1
½ cup fruit juice containing sugar*	15	1
1 medium apple	21	1.4
½ cup applesauce	23	1.5
½ cup mashed potatoes	16	1
½ cup cooked corn kernels	21	1.4
½ cup cooked carrots	8	.5
½ cup cooked green beans	5	.3
½ cup cooked spinach	3	.2
4 oz roast chicken	0	0
4 oz cooked hamburger patty	0	0
½ cup skim milk*	6	.4
1 egg	0.5	0

\*This is considered a fast-acting carbohydrate





## Procedure for Blood Glucose Testing

- 1) Wash your hands.
- 2) Assemble supplies
  - alcohol pad
  - lancet and lancing device
  - blood testing meter (glucometer)
  - appropriate blood testing strips
  - tissue
  - gloves
  - sharps container
  - Diabetes Treatment Log
- 3) If assisting or performing testing for child, put on disposable gloves.
- 4) Have child wash and dry hands or test site thoroughly with soap and water. Make sure the site is dry before testing.
- 5) Turn on meter and insert a glucose testing strip into electronic meter according to manufacturer's instructions. If applicable to specific meter child uses, check the strip code number on the meter and the code number on the container of test strips. If they don't match, correct the code number on the meter.
- 6) Prepare the lancing device according to manufacturer's instructions. Wipe the lancet end of the lancing device with an alcohol wipe before use. Place the lancet in the lancing device.
- 7) Select a test site. If using a finger, use the sides of fingertip. Hang the arm below the level of the heart for 30 seconds to increase blood flow. **If hypoglycemia is suspected: only use the finger for testing, do not use alternate testing site.**
- 8) Hold the lancing device to the side of the fingertip and push the button to prick the skin. Gently squeeze the finger in a downward motion to obtain a large enough drop of blood to cover the test pad on the test strip. *Avoid squeezing the site excessively.*
- 9) Place blood on testing strip and complete testing, according to manufacturer's instructions. Compress the lanced area with tissue or cotton ball until bleeding stops.
- 10) Confirm that the meter is displaying a blood glucose result – not an error message which would require re-doing the test. Remove test strip and clean the lancing device with an alcohol wipe. Dispose of test strip and tissue or cotton ball in lined wastebasket. Dispose



## Handout G.1

of the lancet (just the blade) in sharps container.

- 11) Then remove and dispose of gloves. Wash hands.
- 12) Record blood glucose results in the child's log of medication administration and diabetes treatment log.
- 13) Refer to child's DMMP for appropriate actions.





- Use this form to document all medication administered in the child day program.
- This form must be kept with the child’s medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD’S NAME: \_\_\_\_\_ MEDICATION: \_\_\_\_\_

COMPLETE FOR ALL DOSES GIVEN					COMPLETE WHEN SIDE EFFECTS ARE NOTED	COMPLETE FOR ‘AS NEEDED’ MEDICATION ONLY		
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Were parents notified?	The symptoms the child had that indicated that the medication was needed	Were parents notified?
			AM <input type="checkbox"/> PM <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
			AM <input type="checkbox"/> PM <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
			AM <input type="checkbox"/> PM <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
			AM <input type="checkbox"/> PM <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
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**Complete this section for any medication dose that was not given as written on the child's medication consent form.**

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:



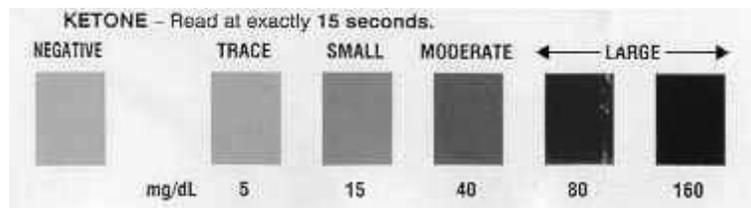
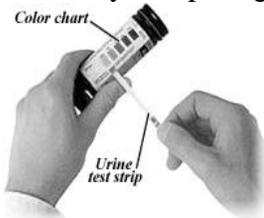
## Procedure for Testing Urine



- 1) Wash your hands.
- 2) Gather supplies:
  - bottle of ketone test strips
  - urine cup
  - gloves
  - clock or watch with second hand
  - tissue
- 3) Have child urinate into cup.
- 4) Put on gloves. Dip the test strip into the urine and shake off excess urine into lined trash receptacle.



- 5) Wait the specified amount of time in the directions on the bottle of test strips, usually 15 to 60 seconds.
- 6) Place the strip on a tissue. Remove and dispose of gloves now, so that you don't contaminate the strip jar when comparing the reference colors to the test strip. Read the results by comparing the color on the test strip to the chart on the bottle.



- 7) Record the results on the child's Diabetes Treatment Log. Without touching the test strip, gather tissue around the strip, and dispose of tissue and test strip. Take action per the DMMP.





Child's Name: Sally Sample Target Glucose: 120

Child Day Program Name: Sample Day Care

**Diabetes Treatment Log:**

Parent or Guardian Name: Sam Sample

Date	Time	Blood Glucose	Ketones	Carbo-hydrates	Insulin Dose	Verified by (Initials)	Glucagon Dose	Site	Administered by: (Print name and sign)	Symptoms/Notes
6/3/13	9:00 am	100				ABC		R index finger	Jane Provider Jane Provider	
6/3/13	10:00 am		Small-15			ABC			Jane Provider Jane Provider	
6/3/13	11:45 am				5 units	ABC		R upper arm, injection SC	Jane Provider Jane Provider	
6/3/13	12:00 am			30		ABC			Jane Provider Jane Provider	
6/3/13	3:25 pm	35				ABC			Jane Provider Jane Provider	Unconscious
6/3/13	3:30 pm					ABC	1 mg	R thigh, injection IM	Jane Provider Jane Provider	Unconscious

**Key:** **Time** (includes a.m. or p.m.); **Blood Glucose** (mg/dl); **Ketones** (negative, trace, small, moderate or large); **Carbohydrates** (grams); **Insulin Dose** (units); **Site** (Including Right or Left Side of Body. R = right, L = left, and Type of Injection (SC or IM))

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child’s medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD’S NAME: Sally Sample MEDICATION: Humalog Insulin

COMPLETE FOR ALL DOSES GIVEN					COMPLETE WHEN SIDE EFFECTS ARE NOTED	COMPLETE FOR ‘AS NEEDED’ MEDICATION ONLY		
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Were parents notified?	The symptoms the child had that indicated that the medication was needed	Were parents notified?
6/3/13	5 units	R upper arm, injection SC	11:45 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	Jane Provider <i>Jane Provider</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
			AM <input type="checkbox"/> PM <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
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**Complete this section for any medication dose that was not given as written on the child's medication consent form.**

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:

- Use this form to document all medication administered in the child day program.
- This form must be kept with the child’s medication consent form.
- Any medication errors (such as incorrect dose given) must be documented on the back of this form **and** on the MAT Medication Error Reporting Form.
- If the child refuses or vomits up a dose, this is not a medication error, but the missed dose should be documented on the back of this form and the parent should be notified.

CHILD’S NAME: Sally Sample MEDICATION: Glucagon

COMPLETE FOR ALL DOSES GIVEN					COMPLETE WHEN SIDE EFFECTS ARE NOTED	COMPLETE FOR ‘AS NEEDED’ MEDICATION ONLY		
Date Given (M/D/Y)	Dose	Route	Time (AM or PM)	Administered by (full signature and print name)	Any Noted Side Effects	Were parents notified?	The symptoms the child had that indicated that the medication was needed	Were parents notified?
6/3/13	1 mg	R thigh, injection IM	3:30 AM <input type="checkbox"/> PM <input checked="" type="checkbox"/>	Jane Provider <i>Jane Provider</i>		Yes <input type="checkbox"/> No <input type="checkbox"/>	Unconscious and blood glucose 35	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
			AM <input type="checkbox"/> PM <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
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**Complete this section for any medication dose that was not given as written on the child's medication consent form.**

Date and time of missed dose or error	Details of missed dose or medication error (included reason error occurred)	Parents notified (date and time)	Signature of Provider / Print Name

Notes:




## Calculating Insulin Dosage

Insulin dosage is based on two calculations: a ratio of insulin-to-carbs eaten and a correction factor. These ratios are specified in the DMMP by the prescribing health care provider.

- The **insulin-to-carb ratio** is the amount of insulin given to cover for a stated amount of carbs that are eaten. The prescriber will commonly express it as a ratio, for example 1:15. The amount is individualized by child in his/her DMMP and the ratio may even vary by meal.

### Sample calculation of an insulin-to-carb ratio:

The child's lunchtime insulin-to-carb ratio is 1:15.

The child ate 60 grams of carbs. The formula is:

$$60 \div 15 = 4 \text{ units of insulin}$$

60 grams carbs

Divided by 15 (ratio)

**4 unit insulin dose**

- The **correction factor** is the amount of insulin the child needs to lower the BG into target range. The target blood glucose is subtracted from the actual pre-meal blood glucose. The prescriber will specify how much insulin is required for results that are over the target blood glucose. This calculation is child-specific and may vary.
- A **correction dose** should not be given within the 2 hours after: eating carbs, a previous correction dose, or treatment for a low blood glucose unless there is a specific order from the health care prescriber.

### Sample calculation of a correction dose:

The child's pre-meal BG is 300. The child's target BG is 150. The correction dose is 1 unit of insulin for every 50 mg/dL over 150. The formula is:

$$300 - 150 = 150 \div 50 = 3 \text{ units of insulin}$$

300 (actual glucose)

- 150 (target glucose)

150 (amount over)

**150 ÷ 50 = 3 units of insulin correction dose**

- The two calculations are then added together to obtain the insulin dosage for the child. Insulin dosage calculations should be maintained as documentation.

### Sample calculation of total insulin dose

Insulin-to-carb dose plus correction dose = total units

The formula is:

$$4 + 3 = 7 \text{ units of rapid-acting insulin}$$

4 unit insulin dose

+ 3 unit correction dose

**7 unit total insulin dose**





## Procedure for Insulin Administration by Syringe



This injection procedure is for the administration of regular or rapid-acting insulin, not for mixing with other insulin.

- 1) Check blood glucose if required by DMMP
- 2) Determine insulin dose per DMMP
- 3) Assemble equipment
  - vial of insulin (*check the Five Rights*)
  - insulin syringe and needle
  - alcohol prep pad
  - gloves
  - sharps container
  - tissue
- 4) Wash your hands.
- 5) If insulin is cold, warm the vial in the palm of the hand to room temperature.
- 6) If this is a new bottle of insulin, remove the flat, colored cap. Record the date the bottle is opened and the initials of the person who opened the bottle on the label. **Do not** remove the rubber stopper or the metal band under the cap. **Check expiration date** of the vial of insulin. If the bottle was previously opened, also check the date it was opened.
- 7) Clean the rubber top of the insulin vial with an alcohol wipe and let dry for a few seconds.
- 8) Remove the cap from the syringe. Fill the syringe with air equal to the number of units of insulin needed. Insert the needle into the bottle and inject this air into the insulin bottle. With the needle in the bottle, turn the bottle upside down and pull plunger back past the number of units needed. Clear any air by pulling plunger back and tapping the syringe to raise air bubbles to the top. Push plunger to desired amount of units, ensuring that no air bubbles remain and withdraw the syringe. Have a second MAT Diabetes certified person check the syringe for dosage accuracy.



## Handout H.2

- 9) Slip needle back into cap without touching cap or needle.
- 10) Put on gloves, select the injection site, clean the site with alcohol and let dry. The best sites are the lower abdomen, followed by the upper, outer arms, tops of the thighs and the upper areas of the buttocks.
- 11) Check the insulin dose, verifying the Five Rights. Remove the cap from the syringe. Pinch up skin with one hand. With the other hand, hold the syringe. Push the needle into the “soft pocket” at a 90 degree angle.
- 12) Push the plunger in to inject insulin in one to five seconds. Do not aspirate or pull back the plunger.
- 13) Release pinched up skin, count to five, then remove needle while applying gentle pressure at the injection site for 10-15 seconds.
- 14) Dispose of syringe with needle intact into a sharps container. **Do Not Recap Syringe.**
- 15) Remove and dispose of gloves. Document in child’s log of medication and diabetes treatment log, checking the Five Rights just before documenting the dose.



# Procedure for Insulin Administration by Pen Injector



- 1) Check the child's blood glucose if required in DMMP.
- 2) Determine insulin dose per DMMP.
- 3) Assemble equipment:
  - insulin pen device (*check the Five Rights when you get the insulin pen*)
  - pen needle
  - alcohol prep pad
  - gloves
  - sharps container
  - tissue
- 4) Wash your hands and put on gloves.
- 5) Check the level of insulin remaining in the insulin cartridge. Ensure that enough insulin remains in the cartridge for accurate dosing. Check the expiration date of the insulin.
- 6) Clean the injection site with alcohol and allow to dry.
- 7) Wipe the needle end of the pen with an alcohol wipe, then attach a new needle. Remove outer plastic cap and plastic needle cover. Place outer cap on a flat surface with open end facing up.
- 8) Dial in 2 units of insulin and perform an "air shot" to "prime" the needle. Insulin should appear at the needle tip; if it does not, repeat procedure.
- 9) Dial in prescribed dose and check the Five Rights. Have a second MAT Diabetes certified person check the pen injector for dosage accuracy.
- 10) Pinch up the skin at the selected site and push the needle into the soft pocket at a 90 degree angle.
- 11) Push the plunger down and inject insulin at a steady rate.
- 12) Release the pinch and count slowly to five and then remove the needle.



### Handout H.3

- 13) Grasping the pen, place the needle into plastic needle cap that was left upright on a flat surface. Unscrew the needle tip and carefully discard into a sharps container. *Do not lift the cap up with fingers to cover needle tip. Leave cap on the counter and use the pen to place the needle into cap to avoid the possibility of a needle stick.*
  
- 14) Remove and discard gloves. Document appropriately in child's log of medication administration and Diabetes Treatment Log, doing the third check of the Five Rights just before documenting.

## Insulin Injection Sites

The image below illustrates the recommended injection sites for insulin in children.

It's important to remember to rotate the sites – inject each dose into a different site.







## Symptoms and Treatment of Hyperglycemia

Hyperglycemia, or “high blood sugar”, or high blood glucose (BG), is when the level of sugar in the blood is greater than 240 mg/dL.

The usual signs of hyperglycemia are:

Mild	Moderate	Severe
<ul style="list-style-type: none"> <li>• Blood glucose usually over 240</li> <li>• Increased thirst</li> <li>• Frequent urination</li> <li>• Fatigue/sleepiness</li> <li>• Increased hunger</li> <li>• Loss of concentration</li> <li>• Blurred vision</li> <li>• Urine ketones (0-small)</li> </ul>	<ul style="list-style-type: none"> <li>• Blood glucose usually over 240</li> <li>• Sweet breath</li> <li>• Dry mouth</li> <li>• Nausea</li> <li>• Stomach cramps</li> <li>• Vomiting</li> <li>• Urine Ketones (Moderate-Large)</li> </ul>	<ul style="list-style-type: none"> <li>• Blood glucose usually over 240</li> <li>• Labored breathing</li> <li>• Very weak</li> <li>• Confused</li> <li>• Unconscious</li> <li>• Urine ketones (Moderate-Large)</li> </ul>

The goal of treatment is to lower the blood glucose. Each child should have a DMMP that is consulted to determine the plan of action. Treatment is dependent on how high the blood sugar is, whether or not urine ketones are present, and if the child is symptomatic. Possible interventions include administering additional insulin, encouraging sugar-free fluids such as water and diet soda, checking urine ketones, and limiting physical activity.

Mild	Moderate	Severe
<ol style="list-style-type: none"> <li>1. Drink zero-calorie fluids (i.e. water)</li> <li>2. Check urine ketones</li> <li>3. Decrease activity if ketones present</li> <li>4. Notify parents/guardians</li> </ol>	<ol style="list-style-type: none"> <li>1. Drink zero-calorie fluids (i.e. water)</li> <li>2. Check urine ketones</li> <li>3. Decrease activity</li> <li>4. Call the doctor</li> <li>5. Administer anti-nausea suppository if prescribed</li> <li>6. Notify parents/guardians</li> </ol>	<ol style="list-style-type: none"> <li>1. Call 911</li> <li>2. Notify parents/guardians</li> <li>3. Notify health care provider if parent cannot be reached</li> </ol>





## Symptoms and Treatment of Hypoglycemia

Hypoglycemia, also called “low blood sugar” or “low blood glucose”, is usually defined as blood glucose values below 70 mg/dL. It is the greatest immediate danger to children with diabetes. **Low blood sugar can develop within minutes and requires immediate attention. Never send a child with suspected “low blood sugar” anywhere alone or with a caregiver who is untrained in basic diabetes management/emergency care.**

Symptoms vary from person to person and from episode to episode. Warning signs and symptoms of low blood sugar happen suddenly and can be mistaken for misbehavior. Many children will not have an awareness of low blood sugar symptoms until around ages 7 or 8 years. The usual signs of hypoglycemia are:

Mild/Moderate	Severe
<ul style="list-style-type: none"><li>○ shakiness</li><li>○ weakness</li><li>○ dizziness</li><li>○ cold, clammy skin</li><li>○ hunger</li><li>○ drowsiness</li><li>○ sweating</li><li>○ paleness</li><li>○ rapid heart beat</li><li>○ visual disturbances</li><li>○ complaining of “feeling funny”</li><li>○ numbness or tingling of lips</li><li>○ yawning</li><li>○ headache</li><li>○ confusion</li><li>○ inability to concentrate</li><li>○ changes in behavior (irritability, crying, combativeness)</li><li>○ slurred speech</li><li>○ nausea</li></ul>	<ul style="list-style-type: none"><li>○ inability to swallow</li><li>○ unconsciousness (extreme cases)</li><li>○ seizures (extreme cases)</li></ul>

Treatment is dependent on the severity of the symptoms. Since some of the symptoms are similar to those for hyperglycemia, **always treat for hypoglycemia if in doubt**. Specific treatment should be outlined in the DMMP, but will look similar to the information given below:

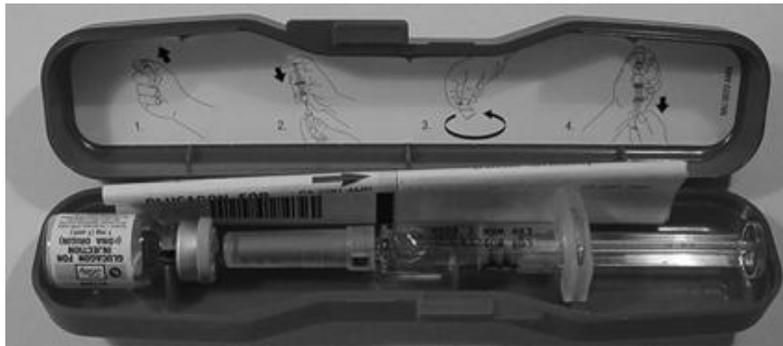
<p><b>Treatment for Children That Can Swallow</b></p>	<p><b>Treatment for Children that Cannot Swallow</b>  <b>*This is a Medical EMERGENCY</b></p>
<ol style="list-style-type: none"> <li>1. Treat with 15 grams of a fast-acting carbohydrate source. Examples of appropriate foods:               <ul style="list-style-type: none"> <li>○ 4 oz. juice</li> <li>○ 6-8 oz. regular soda</li> <li>○ 2-4 glucose tablets</li> <li>○ 5-6 Lifesavers or similar candy</li> <li>○ 6-8 oz. fat free milk</li> </ul> </li> <li>2. Wait 15 minutes, then recheck the blood sugar.</li> <li>3. If the blood sugar is less than the target range, keep repeating the 15 grams of carbohydrate and rechecking blood sugar level 15 minutes later until the BG level is back in the desired range. If unable to raise the BG to &gt; 70 mg/dL despite fast-acting glucose sources, notify the parent/guardian immediately. Refer to the DMMP for the number of times to treat before contacting the parent/guardian.</li> <li>4. When the blood sugar level is back in the target range, usually over 70 mg/dL, and it is time for a snack or meal, allow the child to eat as usual and cover the meal with insulin as ordered. If the meal or snack time is more than an hour away or the child will be participating in physical activity, give a protein and carbohydrate snack.               Examples of appropriate foods:               <ul style="list-style-type: none"> <li>○ ½ sandwich with ½ cup milk</li> <li>○ 4 graham crackers squares with peanut butter or cheese</li> <li>○ 6 saltine crackers with peanut butter or cheese</li> </ul> </li> </ol>	<p>They may be unconscious, unresponsive or having a seizure. Never attempt to give the child food or drink or put anything in the mouth when a child is experiencing these symptoms!</p> <ol style="list-style-type: none"> <li>1. Call 911.</li> <li>2. Position child on his/her left side in a safe area. After administration of glucagon, as the child regains consciousness, nausea and vomiting usually occurs.</li> <li>3. Inject glucagon following the correct procedure.</li> <li>4. Notify parents/guardians.</li> </ol>



## Procedure for Administering Glucagon for Severe Hypoglycemia



- 1) Verify signs of severe low blood glucose- child has blood glucose that meets the criteria for emergency glucose administration in the child's DMMP and/or other criteria in the DMMP or Hypoglycemia Emergency Care Plan such as:
  - unable to swallow
  - unconscious
  - combative/uncooperative
  - having seizures
- 2) Have someone call emergency medical services (911) and family. Do not leave the child unattended.
- 3) Place child on left side or in upright position if restless/uncooperative. Maintain head position to one side to prevent aspiration.
- 4) Get the child's glucagon kit, alcohol wipes, gloves and tissues. Check the Five Rights. Wash hands (if possible) and put on gloves.



- 5) Flip cap off of the glass vial (bottle) containing the dry powder. Remove the needle cover from the syringe.
- 6) Mix the glucagon. Inject the fluid in the fluid-filled syringe into the vial containing the glucagon powder. Shake gently or roll to mix until all powder is dissolved and solution is clear. Inspect medication for color, clarity, and presence of lumps. Solution should be clear and colorless.



**Handout J.2**

- 7) Load the glucagon dose into the syringe. Hold the vial upside down and withdraw the prescribed amount of glucagon into the syringe. **Consult the child's DMMP and/or Glucagon Consent Form for the prescribed amount.**
- 8) Select the injection site. When possible, the injection site should be exposed and cleaned. However, glucagon can be administered through clothing, if necessary. Suggested sites include the outer thigh, upper outer buttock, or arm.
- 9) Inject the glucagon. Push the needle straight into the muscle of the selected site and inject glucagon.
- 10) Withdraw the needle and press the site with a tissue. Massage the injection site for 10 seconds; apply bandage if needed.
- 11) Do not recap syringe. Put used syringe in glucagon kit container. Remove and properly dispose of gloves.
- 12) Stay with the child. It may take 15-20 minutes for the child to regain consciousness.
- 13) Recheck the blood sugar 20 minutes after administration. Follow the child's DMMP or Emergency Hypoglycemia plan for response to results. Some children may have a second injection of glucagon ordered if glucose remains low.
- 14) The child may be given sips of fruit juice or regular soda once awake and able to drink. This may be followed by a snack containing protein and carbohydrates such as a peanut butter sandwich or cheese crackers to keep blood sugar levels elevated to normal levels and to prevent recurrence.
- 15) Do not be surprised if the child does not remember being unconscious, is incoherent or has a headache. The blood sugar may also rise over 200 and nausea or vomiting may occur.
- 16) When emergency services arrive, have the child transported for medical care. Give the used glucagon kit to the EMT.
- 17) Document in the child's log of medication administration and Diabetes Treatment Log.



## Medication and Supplies List for Diabetes Care in a Child Day Program Setting

Parents/guardians of children with diabetes will need to provide the child care provider with all the necessary medication, equipment, and/or supplies required to handle the child's medical needs. The following supplies should be available in the child care setting and will need to be replaced by the parent/guardian as they are used. These include, but are not limited to:

- insulin in properly labeled prescription vial from a pharmacy
- insulin syringes or 1-2 pump change set-ups or insulin pen and disposable needles
- ketone test strips
- alcohol swabs
- hypoglycemia treatment supplies (e.g., glucose tablets, small juice boxes, crackers)
- blood glucose meter and test strips
- lancing device and lancets
- glucagon emergency kit
- snacks (i.e. cheese or peanut butter crackers)
- sharps container (puncture-proof, labeled, and sealed plastic containers such as empty bleach bottles can be used as a substitute)
- band aids
- tissues
- waste receptacle